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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Mother and child in a clinic waiting room. The patience and love suggested by their attitudes are reminders of the "long experience in coping with problems of survival" that comes with being poor (see pages 104–108), and of the strength in individuals which may be overlooked when generalizations are made about the "culture of poverty" (see pages 99–103).

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In 1964, while preparing draft legislation for Connecticut's program of protective services, I became convinced that adequate legal procedures for implementing such programs, there and in other States, were being forgotten in the growing concern over child neglect and abuse, and that the brushing aside of a legal apparatus designed to insure reasoned decision-making might have serious consequences, not only for the social work profession but also for people caught in the State's machinery for dealing with child neglect. What follows is an attempt to suggest some basic questions and statutory provisions which could resolve them.

Protective services are more easily described than defined. In carrying them out, a social agency receives neglect referrals from police, schools, courts, neighbors, physicians, and other social agencies. Then, the agency sends a social worker to the family's home. He confronts the parents with the community's concern and tries to learn about the quality of child care they do, or could, provide. When this care is inadequate, the worker offers to help them, through social work counseling, to improve their parental qualities and so to avoid juvenile court action and possible loss of their children's custody. The social worker may continue to see the family for a short period, or indefinitely, depending on the situation. He is not empowered to remove the children from the home, but if he thinks the children are in danger, his agency may petition the court for their removal.

This type of service has been called "authoritative reaching out" because it is part of the State's authoritative response to neglect, furnished to parents who have not requested it. The establishment of such a service has grown out of the long-time recognition that juvenile court action treats only the terminal stages of neglect and so is too little and too late.

Several excellent studies of protective services have demonstrated that approximately two-thirds of the families served improve sufficiently to make formal court action unnecessary. Such programs represent a move toward alleviating the social cost of neglect and thus justify an authoritative approach in efforts to stimulate parental change.

The legal problem

In States having no legislation authorizing protective services, some form of juvenile court act provides the sole authority for the State to intervene in cases of neglect. Under juvenile court laws, a parent

KIMBERLY B. CHENEY

SAFEGUARDING LEGAL RIGHTS IN PROVIDING PROTECTIVE SERVICES

alleged to be neglectful is protected from State power by the requirements of due process of law. The parent is given notice of the neglect petition, is entitled to a hearing at which he can contest the truth of the allegations before a judicial officer, and is protected from ill-founded action by the rules of evidence and other court procedures. Finally, if the facts alleged in the petition are proved, the court must decide on a disposition of the case in accordance with alternatives provided by statute. Frequently the parent is allowed to retain custody of the child subject to the supervision of a probation officer.

In protective services, the social worker is part of an administrative agency, separate from the juvenile court and empowered to provide the type of supervision to the home that a court may order, but solely on the basis of a social study in which legal considerations may be absent. The standards of care expected of the family under this supervision are set by the agency at its own discretion and may vary as the needs of therapy require. Moreover, the agency's criteria for intervention can be based on a lesser degree of neglect than is necessary to sustain an adjudication of neglect in the juvenile court; for the purpose of protective services is to treat incipient neglect and to resort to the court only when effective treatment has proved to be impossible.

"Neglect," however, is a concept which permits no degree of certainty, either in legal definition or social application. Most neglect statutes are broadly drawn. Such phrases as "proper care" and "conditions prejudicial to a child's well-being" define the conditions on which the State may act. These standards do no more than import vague subjective tests into a legal criterion. Commentators on the juvenile court generally agree that protection from this vagueness must be found in the wisdom of judges rather than in the detail of statute. But they also recognize that the vagueness "enables judges to conceal any kind of result behind . . . pious intonation(s) . . ." and "encourages slipshod decisions which stop short of workmanlike analysis and the decision of important legal issues." [1]

Even when judges try to articulate a legal or social criterion of neglect, which could be a guideline for a protective worker, the results are not uniform. Judicial standards for parental care range from a "reasonably prudent man" test carried over from the law of negligence [2] to a "demonstrated incapacity or something akin to criminal neglect." [3] Perhaps the standard most generally followed is, as Monrad Paulsen suggests, the minimum quality of care which the community will tolerate.[4] One judge, in a well-justified dissent, said that a decision should be based on "all of the many-colored hues going to make up the spectrum of life." [5] Thus there is no agreement on the fundamental question of what standard of care the law requires of parents.

To make matters worse, there are almost no written juvenile court opinions dealing with neglect, and few appellate decisions. Thus a protective worker in determining whether to refer a case to court must rely on his personal or hearsay knowledge of what the judge has done in the past. Conversely, juvenile court judges frequently have to base a decision on their evaluation of the professional soundness of the social worker presenting the case rather than on the facts alleged in a social study.

Social work as a profession does not provide any clearer criteria. Its emphasis on the emotional and

psychological well-being of the child makes social workers less likely than many judges to interfere with family life on the basis of such forms of value preference such as religion or political beliefs. But their goal of emotional well-being is also based on value preferences.

A social worker may assume for himself a hierarchy of social values and conclude that families are providing children with what they need if they are, for example, adventuresome and generous, motivated by a desire to foster social responsibility, and endowed with spiritual qualities. But such values make precision in goal definition impossible.

Edith Varon once asked five field workers and three supervisors in Massachusetts what criteria their agency used in selecting cases for protective intervention. All agreed that for a woman to live with a man she was not married to was not neglect, but consensus ended there. One worker even responded, "I don't think that's a fair question!" [6]

This question is not only fair but vital. Unanswered it gives validity to the charge that "social casework is not really scientific at all in the sense that it makes a relentless unbiased examination of the facts," but rather "rests on an *a priori* system of values." [7] Without clear criteria, a wilderness of unarticulated values may swiftly involve the State in a family's life for novel reasons. Determining what the criteria should be requires answering the following question: For the promotion of what values should the State intervene in family life?

Any number of factors may be relevant in determining what a child's well-being requires. For example, when a child comes to the attention of the protective agency, should the agency intervene because the child's religious training is neglected, as has sometimes been done, [8, 9] or because his parents strongly advocate communism, as has also been done,[10] or because a racial intermarriage disturbs the family's relationship to the community, as was alleged in a case in Connecticut.[11]

Once the agency decides to intervene, what goals should be set? Should the child be removed to a family of greater wealth or social status or with more acceptable political beliefs? Or, if the child is not removed from his home, should the family be reorganized to strengthen religion or education, or to promote the child's physical well-being, or to make him respect his parents, or to promote family love, or all of these?

What is needed are clear standards and an administrative procedure designed to expose the criteria actually applied in any case to close legal and social scrutiny.

Primary goals

The basic goal of a neglect law is to prevent the social, physical, and psychological deterioration of children. But there is no guarantee that social agencies will not intervene on grounds irrelevant to this standard, as some courts have done. For example, in one case an agency petitioned for the removal of a child because his mother visited taverns,[12] and in another a family lost 5 of their 11 children through adoption while they were petitioning for a reversal of a decision denying the children's return to them because their home was too small.[13] A protective statute should require that the child's physical and mental health be the State's sole interest. Agency discretion would then be limited and court review channeled into an inquiry concerning the child's physical and mental health to the exclusion of other factors.

Even if this is done, the basic issue that still must be faced is what degree of family deterioration should exist before parents are subject to intervention. Is the State to intervene because of a perceived sign of social disorganization, or must it wait until a specified level of disorganization has been reached?

In view of the etiology of neglect and the difficulty of reversing established behavior patterns, some people argue that if the State is justified in intervening at all it ought to do so early. In view of the probable unpleasantness of intervention to the family concerned, and of the uncertainty of psychiatric knowledge, others argue that intervention should only be authorized when objective and severe neglect is evident.

The American Humane Association's model act for protective services is based on the first view. It would authorize protective intervention "in behalf of children whose health or welfare is impaired or

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under immediate threat of impairment as a result of violation"[14] of law. Such authority, if keyed to the already vague definitions of most neglect laws, would be broad indeed.

However, there are several reasons for basing a statute providing for protective services on the second view:

1. An offer of services may be regarded as a form of punishment by parents, and punishment of any type should not be imposed unless there is prohibited conduct in relation to children. Moreover, since the family relationship is the most intimate type of human experience, interference with it should be permitted only on grounds of actual trouble and not on estimates of future harm.

2. The uncertain nature of psychiatric knowledge along with the lack of professional training of many protective workers raises the probability of harm occurring through premature action.

3. Since the vagueness of meaning given to the word "neglect" permits State intervention in practically unlimited and unknowable measure, the advisability of giving the State more rather than less power to intervene may be questioned.

4. Most important, though defined in terms of health, legal neglect is not a question of medical or even a psychiatric judgment, but is essentially a policy issue. Primarily it denotes conduct in conflict with the child-rearing standards in the dominant culture. If the child is in danger, the policy question is not how dangerous the conduct is for the child, but what degree of danger to a child society can tolerate. Granted that social workers have an expertise that enables them to assess the danger in particular circumstances, that fact does not qualify them to fulfill the social role of judging when the State ought to intervene. That decision ought to be made by courts, guided by the legislature, using the social diagnosis as a source of evidence.

Emotional and social neglect

Neglect has long been thought of by legislators exclusively in physical terms. Actually, if a child lives in a proper psychological milieu, he can tolerate some physical deprivation. Standards are available to determine when malnutrition or disease endangers a child's health or when lack of clothing, shelter, or inadequate supervision endangers life or health. Accordingly, minimum physical standards of care can be set by statute without great difficulty and deviation from them judged objectively.

Statutory protection of a child's psychological welfare is more difficult, but equally necessary. The healthy emotional development of a child is as essential to his ability to live in a society as a healthy physical development. Some social workers and psychiatrists have, in fact, argued that judicial decisions and laws which do not recognize emotional neglect, or other forms of mental damage, are archaic. Others believe, on the other hand, that more needs to be known about the causes and treatment of emotional disturbance in children before "emotional neglect" can be made the basis of neglect jurisdiction. Erik Erikson, for example, has pointed out:

> **The psychoanalyst knows relatively more about the dynamics and cure of the disturbances which he treats daily than about the prevention of such disturbances. . . . Strictly speaking, we cannot even be sure that we know what causes neurotic suffering until we have an idea of the nature of real health.[15]**

Thus, the need for action in behalf of emotionally disturbed children is difficult to translate into legal standards because the medical guidelines themselves are uncertain.

Action in this respect on the part of a protective agency is no less fraught with psychic danger to the child than court action, even though under protective services a child remains in his home, while court action may lead to removal. The caseworker's attempt to establish rules could destroy parental ability to control any area of the child's behavior. The mere presence of the worker, representing a new authority in the home, could result in the parent's giving up the vestiges of his own authority or the child's attempting to manipulate one authority against the other. On the other hand, of course, the caseworker could provide the support necessary for the parent to control and guide his child.

Nevertheless, since psychological welfare is so important to the child, since a caseworker may intervene in instances of physical neglect but "treat" for emotional neglect, and since most juvenile courts recognize emotional neglect *de facto*, it would be a wise policy for the legislature to legitimize the situation and at the same time exert control. As it is, protective agencies sometimes treat families for emotional neglect without statutory authority but refrain from taking such cases to court even though the situation fails to improve.[16]

In spite of gaps in current knowledge, psycho-

These children may just be dirty and tired like any children who have been out to play, but if they have been locked out and no adult is on the premises, the community may have cause for concern about their protection. Some intricate questions involved in protecting children from neglect without violating their parents' legal rights are discussed in the accompanying article.

analysts do know a great deal about the essential conditions for healthy emotional and mental growth. They have found an affectionate relationship between mother (or mother substitute) and the child to be most essential, and continuity in this relationship next in importance. If these factors are absent, they point out, it may be impossible for a child to develop a stable, integrated personality.[17-19]

Therefore, legislation designed to protect a child's psychological development might designate the denial of a continuous affectionate relationship as a criterion for intervention in family life, as does the Idaho statute.[20] But unlike that statute, it should not permit intervention based on ideas of normality. Intervention should be restricted to cases where the child's intellectual development or the development of his capacities is seriously retarded. This would not only protect the rights of parents to rear their own children, but would also protect children from actions based on unproved theories. The risk of harm through intervention on the basis of little understood factors should not be tolerated.

If such standards are accepted, the interchange between social workers and lawyers may in time lead to the definition of those emotional factors which are so essential to the growth and development of children that their absence justifies State intervention. The object is to have the right questions asked in court; the hope is that correct answers may evolve.

Society has an interest in protecting itself as well as the child. Therefore, if the child engages in serious antisocial behavior, State intervention in his family life, where the roots of such behavior will probably be found, is justifiable. But the legislation authorizing such interference should clearly indicate that it is the child's behavior and not his parents' that is at issue. For example, if a parent openly engages in immoral sexual relationships, or the use of narcotics or excessive use of alcohol, there is a real risk that these habits may be instilled in the child. But if the parent is discreet about such behavior as far as his child is concerned, the behavior may not adversely affect the child's socialization. In the latter case intervention in the family life would be a punitive attempt to reorganize parental behavior for its own sake and would not be legitimately connected with the goal of advancing the child's welfare.[21, 22] Therefore, a protective statute should exclude the right to intervene in family life because of the parent's behavior unless there is some direct evidence that it is adversely affecting the child.

Due process of law

The United States Constitution forbids depriving a person of liberty without due process of law. And the Supreme Court of the United States has held that "liberty" includes the right of a citizen to be free "to marry, establish a home, and bring up children," and has held privacy to be constitutionally protected.[23, 24] There can be little doubt that protective services may be a deprivation of liberty.

The power [of the social worker] to be there bears with terrible weight upon the parents . . . he must take from the parents what every man cherishes most of all, his right to live in privacy within his own walls. . . . Even the actual removal of the child may not be so hard to bear as an alien presence in the home.[25]

True, many parents will genuinely welcome the intervention of a social worker. Their family situation may have deteriorated into such a morass of hopelessness, or their child's behavior may have become so perplexing, that State initiative in offering help may coincide with their own vague intentions to seek it. In such cases, the requirement of due process of law is satisfied by the parents' acquiescence. But in other cases the services will be resented and even feared and the parents, if they consent at all, may do so only out of fear. Clearly, then, due process guarantees must be met.

Where a person's liberty is involved, the general proposition is that procedural due process requires a hearing in which some tribunal passes on the State's right to intervene. Most protective statutes do not provide for hearings. They either ignore the requirement or they rely on the friction that families given protective services always accept them voluntarily.

True, a parent confronted by a protective worker can obtain a hearing simply by vigorously refusing to accept the services and awaiting the agency's determination to file a neglect petition in the juvenile court. But most parents who are confronted with an offer of protective services may be uncertain of their legal position and may acquiesce only because advice from a social worker seems less threatening than court action. Moreover, many such parents may be recipients of public assistance and may believe that refusing the worker's offer of service may jeopardize their means of sustenance.

In search and seizure cases, even such implicit threats may amount to coercion sufficient to violate a person's constitutional rights under the fourth amendment.[26] Perhaps protective services do not come into the category of constitutionally protected searches. But they are a searching into the minds and behavior of parents with the threat of removal of their children looming in the background. To work with a man's mind should require at least the same safeguards as a search for his chattels.

The best way to meet this obligation is to require a hearing within 60 to 90 days *after* services are offered the family on a voluntary basis under statutory authorization. If the hearing were required *before* any offer of services, the program would be indistinguishable from the present protective supervision used by the juvenile court, and would introduce the element of coercion so apt to produce hostility in parents. Allowing for the *voluntary* acceptance of the offer of services could promote the social worker's chances of developing the kind of helping relationship which can displace hositility with genuine cooperation. And, if the services prove officious, the court could readily terminate them.

The issue at this hearing—unless either protective worker or parent determined that a formal adjudication of neglect should be made—should be limited to the question of whether or not protective services were being administered within the definitions of neglect contained in the protective act and thus may continue. This procedure would not require the judge to become an administrator of the child protective agency. It would give the courts a function especially suited to them: judging whether the State is legitimately intervening in family life to advance the social welfare.

The right to counsel

The final question raised by due process requirements is whether a family should have a right to counsel at the hearing. Since juvenile court hearings need not provide a defendant with the safeguards required in criminal proceedings, counsel is, perhaps, not mandatory. But the absence of procedural safeguards in juvenile courts is not universally applauded. A benevolent deprivation is just as real as a malevolent one.

Edith Varon has aptly illustrated this fact. In commenting on the reaction of some mothers to a letter from the Massachusetts Society for the Prevention of Cruelty to Children initiating contact, she writes:

> **For those who did not know that a complaint was about to be made, the letter was a shock producing agitation and anger. The thought was, as they put it to me, "Who would do such a mean thing?" . . . Mrs. Fossa was so mad she didn't know what to do, and on advice of her neighbors she took the letter to the police.[6]**

Nor was this a transitory reaction. For many, this anger and anxiety "was still churning within them 2 or 3 years later." And if court action ultimately resulted, the feeling was even more bitter.

Of course, providing protective services does not inevitably engender such anger in clients. Much depends on the quality of the worker. One woman interviewed in another study remarked:

> **One thing I definitely like about my worker is that she's always pleasant and cheerful. She's the only person or human being I see all week except my howling, snarling kids and they're always fighting . . . but the minute she comes . . . she makes you feel glad that she's actually there.[27]**

The fact cannot be overlooked that in some parents hostility is aroused by anything which would alter the family pathology on which their own morbid sense of well-being depends. The rights of parents cannot be used to shield parents from their responsibilities to provide appropriate care for their children. But this is no reason to conclude that the court should be invoked "only as a diagnostically dictated step in the treatment process of a specific case," [28] thereby relegating due process to limbo.

The best way to assure both that due process of law is observed and that the values on which decisions are made are clearly stated is by providing parents with counsel if they cannot do so themselves, as New York does. Lawyers could help force those persons concerned with child neglect to grapple with the basic social and legal questions involved. Thus, a protective statute should make provision for counsel at the time of the court review, if requested, and clients should be informed of this right on the initial contact.

In summary, legal procedures are not impediments to swift correction of social ills. Observance of legal rights would help to ensure that protective decisions are based on the reasoned application of relevant criteria. This is more likely to protect children than striking at neglect with unknown values and uncertain policy.

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Too often legislators . . . have operated under the theory that when you remove the people from the welfare rolls you remove their problems as well.

Edgar May, in* "The Wasted Americans," *Harper & Row, New York, 1964.

a psychiatrist suggests some points to be considered in . . .

HELPING PEOPLE WHO CANNOT MANAGE THEIR LIVES

IRVING KAUFMAN, M.D.

When Sigmund Freud first began to treat neurotic patients, he was surprised to find that despite all their verbalized wishes for help they came late for appointments, were irritable, complained that the therapy was taking away something valuable such as their creativity, and in general made it very difficult for treatment to proceed. Seeking the reasons for this resistance to treatment, he found that the patient's pathology was serving important functions in his psychodynamic balance, and that, therefore, in alleviating symptoms the therapist had to take into consideration what he was doing to the person in the process. This discovery led to the focus on ego psychology in contrast to an earlier focus on symptom relief.

For a long time, Freud and the early psychoanalysts felt that there were only certain types of people who could be treated successfully. These were the people who had enough motivation for change and a strong enough ego to tolerate the anxiety that the treatment aroused and to face their conflicts. Orthodox psychoanalysis is still primarily geared to this type of patient.

However, if these were the only people offered treatment, the vast majority of people who need help with their emotional problems would be deprived of it. Actually, the classic psychoneurotic client makes up a relatively small proportion of any psychotherapist's caseload, whether in a social agency or in a private psychoanalytic practice. An increasing proportion of people referred for help are people having difficulty in the management of their lives. For such persons, the traditional psychoanalytical techniques and methods have proved to be highly inappropriate. Therefore, psychotherapists have been trying to work out other more effective methods of treatment.

The core issue has to do with the diagnosis. Ideally, scientific diagnosis requires identifying the etiological agent which produces a specific kind of pathology, runs a definable course, and responds to a specific kind of treatment. To some extent some etiological factors in emotional disturbances can be identified, but for the most part they cannot. This is because an etiological factor in emotional disturbance is much more complicated than the virus, bacteria, or tumor at the base of a physical illness. In the "unmotivated," "hard-to-reach" families and individuals which comprise a protective service caseload, for example, a multitude of different etiological factors appear to be involved, even in persons with similar types of pathology.

The classic psychoneurotic patients, corresponding to those described by Freud, are functioning at a developmental level having certain specific character-

Based on a paper presented at a 1965 Institute on Education for Social Work With Unmotivated Clients, held at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, supported in part by the Children's Bureau.

istics. They are able to use language as a major means of communication. Both the client and the therapist expect a logical connection between the thought and behavior. But persons whose personalities are fixated at more primitive stages of development have less capacity to communicate their thoughts and feelings through words. To a large extent they use behavior as their means of communication.

There are only four possible ways any person can express himself: (1) Through words; (2) through affect; (3) through behavior; and (4) through bodily reactions. The clients seen in social agencies such as a protective agency may use all four of these ways of communicating to some extent. However, many of them use behavior as the dominant mode of expressing their problems, and, in turn, require behavioral response from those who would help them deal with their problems. Instead of developing symbolic symptoms, such as an arm paralysis, or loss of speech, a phobia, or an obsession, such people express their problems by beating up their children, deserting their husband or wife, drinking to excess, walking out on their jobs, or in other forms of behavior which get them into difficulty with society. The children play truant from school; they steal; the girls become pregnant; the parents neglect their children.

Because behavior results in social difficulties, however, does not mean that it is based exclusively on social deprivation. Psychological and social factors are usually intertwined in the etiology of such behavior. Direct manipulation of the social environment is as ineffective in treatment as direct manipulation of psychological symptoms. Hypnotizing a person and curing a conversion reaction may relieve a physical symptom, but in some instances may produce more serious symptoms. Similarly, taking a person from a slum and putting him into a "better" but unfamiliar neighborhood may not cure his social and psychological difficulties. An intermediate step is usually necessary to help people with behavior problems benefit from social improvements.

Difficulties in intervention

This intermediate step is motivation. Most people who work in the mental health fields come from middle class backgrounds. They are used to dealing with a client in terms of their own self-image—as someone who can be dealt with in a rational way. But in many social agencies, particularly protective agencies, they find clients who have come for treatment under external stress, or who have been forced into it by a complaint from a neighbor or by an order from a court. Even enough motivation to seek help, therefore, does not exist.

Intervention by a psychiatrist, social worker, or psychologist in an attempt to help such people overcome their problems can mean something very different to these people from what it *must* mean if it is to be therapeutically effective. The prospect of verbal interaction threatens to interfere with their habitual mode of functioning and so may arouse a great deal of anxiety. Even though their overt disturbance may be a cry for help, they may see the person who comes with an offer of help as someone who threatens to take away their familiar way of relieving anxiety.

What does one do to get help to such people?

Reaching the client is relatively easy when he has come to the therapist of his own volition, saying "I have a problem . . . I want help to overcome it." Such a client comes regularly for appointments, and even though he may show resistance he works on his problems. It is quite another thing when the therapist, usually a social caseworker, must go to interview a client who has not sought his help and who acts as though the therapist were a nuisance or a pest. The treatment problem often becomes even more complicated because of the therapist's own counter-reaction to the negative reaction of the client. In addition, the therapist may feel uncomfortable about imposing his ideas and values on an unwilling client, unless the client is obviously psychotic and dangerous to himself and others, or is severely abusive to his children.

Not many people would say that a parent has the right to break a child's bones or fail to feed him. However, in many neglect cases the issues are not so clear cut, and the caseworker may wonder whether he is imposing something that is not appropriate and whether he is acting out of his own, rather than the client's, needs. These are fair and appropriate questions which a therapist should always ask himself. Nevertheless, the caseworker in a protective agency has a responsibility to determine whether the client is dangerous to himself or to his children—whether intervention is necessary to prevent serious family pathology.

Being rejected by the client may be hard for the caseworker to take because of his own emotional investment in his work. A resultant feeling of discouragement may make it difficult for him to pick

up and deal with the core problems of the client. Partly because of his own discouragement, the caseworker may come to believe that the client does not want to change—in other words, is "unmotivated." When the caseworker is called at all hours of the day and night because of emergencies in the same family—the husband is drunk, the daughter pregnant, the son picked up by the police—he might wonder when it will end, or whether it will ever end, and how he will ever do anything for the family. This is particularly true if the agency environment implies: "These are unmotivated people, get rid of them. We have to save our time for people who wish help." On the other hand, an agency environment which gives the caseworker emotional support and recognition for his efforts in dealing with such very difficult people can help lessen the caseworker's feeling of discouragement and make a tremendous difference in his capacity to cope with the problems they present.

Personality structures

What is the psychic structure of the people who express their emotional problems by unacceptable behavior? Many of them are ambulatory psychotics and even more are persons with impulse-ridden character disorders.

It is easy to make a diagnosis of schizophrenia in a hospitalized client who has hallucinations and is deluded, denudative, and assaultive. However, it is not so easy to diagnose the condition of the disturbed persons with less overt symptoms who are so often seen in social agencies. Anna Freud has pointed out that the ego is a dynamic structure which organizes various defenses depending on the stress it is undergoing.[1] These can be defenses against defenses. Moreover, the same person can at one time exhibit a neurotic pattern of defense and at another time a more nearly psychotic pattern. Such persons might be called "borderline psychotics." They include:

1. **The schizophrenic group.** Classical schizophrenic patterns are isolation, withdrawal, regression, and the use of primary process thinking. Such clients tend to view others as threatening objects, the extreme response being kill or be killed, eat or be eaten, destroy or be destroyed.

If the therapist has a patient who says he is hearing a voice telling him to kill, diagnosis presents no problem. However, a client of a protective agency who views a 3-month-old baby as a horrible monster out to destroy him, although equally psychotic, presents a different diagnostic picture. He may pick the baby up and throw it on the floor and jump on it and kick it, but the next day when brought into court, give a rational story about having lost his temper. Often such a person can hold a job or keep a house clean.

A review of many cases of child abuse has indicated that many abusive parents exhibit an episodic type of psychosis, characterized in extreme cases by wild outbursts of rage.[2] The persons who gave vent to such outbursts had exhibited many positive capacities—for example, they could handle money, hold a job, or manage a household effectively. However, many of them were quite isolated in the community and their relationships with others showed many similarities to those of classical schizophrenics. The episodic form of their psychosis complicates the diagnosis and treatment of such people, especially because many of them at times can be quite gentle and even affectionate with their children.

Persons of this schizophrenic type are also often seen by caseworkers of suburban family service agencies. Many people in this group are highly educated and function well as scientists, professors, university teachers, or in other respected occupations. Yet in other aspects of their life their behavior differs little from that of the borderline psychotics seen in protective settings.

For example, a family service social worker calling at a home found a husband and wife rolling around on the floor biting, kicking, and scratching each other in front of their children. These people, however, were not directly abusive to their children.

In another case, a woman told a social worker in private practice that her husband had grabbed her in front of her children, slammed her against the wall, and threatened her with a knife, saying he was going to skin her alive and tear out her eyes. He had then dragged her across the room and pummeled her, screaming and raving as he did so. This man was a very successful person in his profession and the wife was a very good housekeeper who functioned effectively in many ways.

Before such borderline psychotic clients can be effectively treated, a diagnosis must be reached. The terminology used is less significant than a determination of the level of personality development, the organization of the defense structure, and the capacity for regression.

2. **Character disorders.** Persons with impulse-ridden character disorders come to the attention of

social agencies even more frequently than persons with episodic schizophrenia. Their personalities are fixated at a level between the more deeply regressed psychotic personalities and the neurotic personalities. Such persons account for the bulk of the caseload in a protective agency—most of the neglect cases. The abuse cases occur less frequently and are more likely to involve psychotic personalities. Persons with character disorders also account for the bulk of court and prison caseloads. Such people have major problems in managing the realities of their lives. For example, they may live in a "cold water flat" with a pastel refrigerator bought on credit, without having paid for the electricity to keep it going. They tend to be especially inconsistent in their child-rearing practices.

Persons of this type usually have received inconsistent treatment in their own lives. Usually they have had just enough care and attention to know that something is missing; but for the most part have lived in an atmosphere of deprivation, especially of consistent affectionate relationships and models for identification. Such deprivation and inconsistency have impaired their ego development and fixated their personalities at an infantile stage of development. They behave much like 2- to 3-year-old nursery school children. Many of them have the charm of such children, but they also demonstrate other childish characteristics. For example, their relationships are transient and fleeting. They can engage in some kinds of group activities, but they are likely to go off in some parallel, lone activity while with a group. They tend to use various kinds of projective mechanisms to cope with their problems and to resort to isolation and to repeated compulsive actions when under stress.

Such persons also tend to postpone dealing with problems directly. It is extremely difficult to get them to carry out a responsibilty, however minor, such as going downtown and paying a bill, even if they have been given the money to do so. They may complain about a toothache, be given a dental appointment, and then come up with a reason for not keeping it. They have an enormous amount of difficulty in facing anything involving any stress and tend to use isolation and denial as a way of handling even the simplest daily problems.

Such people also have difficulty in handling their aggressive and sexual impulses.

In normal child development, the child progresses from the direct expression of his instinctual impulses to a gradual neutralization of them through his relationship with the important people in his environment. He then develops an increasing capacity for ego mastery. Persons with an impulse-ridden character disorder have not had the ego-building experience which will enable them to gain gratification out of mastery of their environment. Their resultant tendency to discharge their instinctual tensions through aggressive outbursts or promiscuous sexual behavior creates a multiplicity of problems for themselves and others.

Not only do they come into conflict with the community, but also, because they have not acquired the ability to sublimate, they do poorly in areas requiring this ability. As children, they have difficulty in learning and in social adaptation to school, and as they grow older they have difficulty in job adaption, money management, home care, and care of their children.

Results of pathology

The question can pertinently be asked whether there are some kinds of pathology that make for success in our society and some kinds that make for failure. A certain type of paranoid personality, for example, can be observed in some very shrewd businessmen. A man of this type can outwit everybody and does not care if he harms someone else. He gets his own way, accumulates money, power, college degrees, and honors. His particular type of pathology is quite compatible with success as it is defined in large segments of our society.

In contrast, there is the kind of person who cannot sit still in a classroom and cannot concentrate on school work. He trips or punches anyone who walks by. He does not get to school, or to his job, on time. If he has any money, it runs through his fingers. This type of person does not learn in school or achieve success in our culture. Although there are many people of this type in all socioeconomic groups, there is a tendency for such persons to regress to or remain at a low socioeconomic level, regardless of the level in which they start out.

Implications for treatment

What kind of therapy can be effective with persons whose emotional development has become fixated at an infantile level?

Conversation has much less meaning for persons thus emotionally retarded than for people who have achieved higher developmental levels. Therefore,

they need a caseworker who can communicate with them in other ways.

Anna Freud,[3] Melanie Klein,[4] and other pioneers in child psychiatry have noted the importance of developing a method of communicating with the child needing treatment. Obviously it is not possible to put a child on a couch and say, "Speak of whatever comes to your mind." The first thing the child would say would be, "What can I do next?" Probably his first thought would be, "How do I get out of here?"

This is also true of adults who are not used to discussing problems of any type with anyone. In some work with children from socially, economically, and psychologically deprived backgrounds who have done poorly in school, it has been found that the children did not know how to communicate their wants or thoughts. The experience of being taken on an adult's lap and being talked to affectionately was an entirely new one for them.[5] Obviously, a psychiatrist or social caseworker cannot put an adult on his lap and give him the child-rearing experience he has missed. However, treatment for an emotionally deprived adult has to be a restitutive process before it can be anything else. It has to supply some some of the object relationships and other nurturing and ego-building experiences that have been missing in his life.

The first step is to help such a person build up a recognition of the relationship between cause and effect, the effects on day-to-day living of thinking ahead and planning. For this reason, much of the necessary treatment of families in neglect cases may seem to be at superficial levels.

For example, a mother appears unable to realize that in order to provide breakfast for a child it is necessary to have some milk or cereal in the house—not because she does not have the intelligence to know this, but because her own infantile needs are preventing her from thinking of the needs of the child. The restitutive process involves giving her an experience with someone who goes through the thinking and planning with her as an ego-building process. Trying to deal with her unresolved hostility to her parents or other conflicts may have a place at a later stage in treatment, but not until she has been shown by example ways of dealing with her everyday problems.

Similarly, the person who cannot face going downtown or who cannot keep a dental appointment needs the corrective experience of having a relationship with someone—a caseworker, for example—who not only says, "Here's the money to pay the gas bill," but who also goes along with him on his visit to the dentist.

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There are several reasons for recommending this treatment procedure. Verbal communication has relatively little meaning for such persons. They do not have enough ego to face the stress of doing even those things which are to their advantage. They need the experience of having someone at hand who not only cares enough to be concerned about their problems, but who also helps them face and carry through on their responsibilities for doing something about them. In playing this role, the caseworker can help such a person build up a model of behavior different from his accustomed pattern of fright and avoidance.

There also needs to be restitution of a parent-child experience for such a person at a level which he can understand. The caseworker does not play games with his adult clients, but the process of going to see them and having a cup of coffee with them, giving them material things, or just being present and interested, as in going with them to the doctor, provides this kind of restitution.

Unfortunately this type of casework approach to the client has less prestige in the social work profession than the psychoanalytic, interpretive, confrontation sort of procedure. Nevertheless, the therapist must deal with the client at the point where he is. One does not start interpreting personality dynamics and confronting a person with his psychological shortcomings if he cannot plan how to get breakfast for his child or get his clothes ready.

The question often arises: Can this type of planning be called treatment? Of course it can. It is treatment based on a diagnosis of the client's level of development. It is treatment based on what the client needs in the way of ego building. It is exactly appropriate. Although a different type of treatment may be called for as the client progresses, the approach needs to be geared at all times to his level of

fixation, the structure of his defenses, and the way he reacts to others.

The agencies

Social agencies deal with many people whose life experiences have been marked by inconsistency, desertion, a feeling that no one cares. Such people often act in ways which antagonize the community. As a result, the development of the social agency structure in most communities has been in response to each of the protrusions of a huge iceberg. As a result, there is a tendency for the various parts of these problems to be dealt with in discordant ways.

While efforts are constantly made to coordinate programs, more needs to be done to give the families served some consistency in approach and in philosophy. For example, one agency may be working with a boy who is in court for stealing; another, with his sister, an unwed mother seeking placement of her baby; and another, with the parents in an effort to help them provide a better home life. All of the agencies may be doing excellent jobs, but such a multiple-agency approach is in effect repeating the same kind of inconsistency which people who have so many problems have experienced all their lives. When people have never had any consistent parental care in their own childhoods—have perhaps been shifted from foster home to foster home—the experience of having a profusion or succession of counselors or authority figures intervening in their family life may merely accentuate their feeling of not being able to count on a continuing relationship with one person who cares what happens to them.

In addition, there is the problem of dealing with the community's antagonism to such people. Because people who are emotionally retarded often do things other members of the community do not like, persons who work with them tend to get discouraged. Some public agency policies seem to reflect a desire to get rid of as many such people as possible by giving them a one-way ticket to another State, or by putting those who behave in antisocial ways in institutions in isolated rural areas where they will not disrupt the community.

However, the objective of treatment is to help emotionally retarded people become members of the community and to develop an ability to care about other people. This cannot be achieved by policies which are an expression of hostility and which serve to isolate such people from the community even more than they already are.

The problem of dealing with people who act out their emotional problems is not limited to social agencies which see people from the lower socioeconomic groups. Therapists in private practice see many people from middle and upper class families who behave in a similar fashion. Their children behave very much like the children seen by a youth service board, a family service agency, or a protective service agency. They have the same kinds of learning disabilities, they cannot concentrate on school work or sit still in the classroom, and they make nuisances of themselves. Some of them use drugs, and some of the girls get pregnant.

Therapy is as difficult with these children and their families as with children from lower socioeconomic groups. Their attitude toward authority is equally hostile. They are brought to the therapist's attention chiefly because they are not doing well in school, and their parents are worried that they will not get into a good college. But the parents show the same unconscious drive to perpetuate the children's pathology as do the parents of lower socioeconomic status whose children are in trouble. For example, they do not ask their children appropriate questions. If a boy comes home with a wagon that does not belong to him, they do not ask him where he got it.

No matter what socioeconomic group an "unmotivated" client comes from, therapy to be effective must be based on the following considerations: (1) Diagnosis in terms of personality level; (2) what this implies in regard to the treatment approach; (3) how he is likely to interact with others; and (4) what kinds of direct and indirect social objectives are involved in treating him.

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analyses of studies of social class subcultures provoke comments on . . .

SOME DIFFERENCES BETWEEN PEOPLE AND STATISTICS

CATHERINE S. CHILMAN

Investigations by social scientists into the causes and characteristics of poverty have mushroomed in recent years. Social research has moved out of once impoverished, academic closets into a new affluence of prestige and increasing methodological competence. It occupies a front-row seat in the arena of community action. Social researchers are investigating many important problems, including those related to social class structure and patterns of living. Their studies are throwing increasing light on some important questions concerning, among other things, the causes and effects of poverty.

Administrators and practitioners who seek to help the poor are eager to get as much enlightenment as they can from the researchers. And most researchers are eager to provide it. However, scientific investigation has many limitations which prevent quick, general "breakthroughs" in knowledge that can be readily applied in action programs. While the conscientious social scientist presents his findings with a multitude of warnings as to their limitations, these warnings tend to get lost or disguised in the translation of research findings into a readable, understandable form for action-oriented consumers.

Research findings must, of course, be translated for a wider audience so that they can be put to use, but precautions are necessary. Some of the most important precautions for those who would apply studies of social class in dealing with people in need of services will be presented in this article. Although it is focused on research about the cultural patterns of the very poor, most of the precautions are also in order in applying the findings of other bodies of social research.

Although further research may reveal that certain characteristic life patterns are found in the culture of the poor in all Western societies, it seems premature to embrace this contention too ardently. Studies in this area are relatively few, the samples studied have been small and not necessarily representative of the larger population, and methods of study have tended to be observational and intuitive and subject to the biases and perceptions of the interviewers. Greater scientific precision is being developed in this area of research, as well as in others, but the time has not yet come when great confidence can be placed in results.

It would probably be more accurate to talk about the *sub*cultures of poverty. The prefix "sub" is used because most of our poor would seem to subscribe to the "middle-class American way" as a cultural ideal,

Based on the introductory chapters to a forthcoming volume by Dr. Chilman, "Growing Up Poor," an analysis of the child-rearing and family life patterns of the very poor, to be published by the Welfare Administration in June 1966.

at least, which they accept, in theory and fantasy. Hyman Rodman,[1] for instance talks about the "middle-class value stretch." By this he means that the poor, caught in a situation of economic deprivation and social disorganization, stretch and adapt the values of the middle class to the realities of their own lives. Myers and Roberts[2] are among those who discuss the necessity for the poor to have a pragmatic, materialistic, present-oriented attitude, pointing out that when getting and holding a job and buying food are paramount necessities of the moment, many middle-class values, such as a consideration of the subtleties of human relationships, are necessarily pushed to the background.

Subcultures of the poor

The term "subcultures" seems more appropriate than "subculture." This is because research on other aspects of varying cultures, as well as common observation in working with low-income people from various backgrounds, would strongly suggest that among those who live in poverty there is a wide variety of differing living patterns, associated with race, religion, region of the country, national background, rural-urban locale, exact social class level, age, and sex. Some recent studies of low-income cultures have examined questions of racial patterns within the same social class;[3-5] some have examined patterns in relation to both masculine and feminine roles;[6-7] some have looked at the subcultures of the adolescent poor;[8-10] and a very few studies have carefully differentiated their population as being either working class (upper lower or middle lower) or lower-lower class.[11] On this point, Elizabeth Herzog has commented:

> . . . Reference to the poor does not, of course, mean the lower layer of a three-way breakdown into upper, middle, and lower socioeconomic groups. We have had abundant evidence that this lower segment of the traditional three-way break is itself divided into a number of layers. We have evidence, too, that the life-ways of the very lowest layer differ from the others in this same band more than the so-called upper-lower differs from the lower-middle.[12]

She goes on to say that ". . . the ill-defined group referred to as 'the poor' does not include the stable, respectable working class [the skilled and semiskilled blue-collar workers]." Since many studies of lower class culture do not make adequate discrimination between this class of steady workers and layers below it, assumptions about the "culture of poverty" may, in at least some cases, be wrong ones. Moreover, evidence is emerging from studies of recipients in the program of aid to families with dependent children (AFDC) and others of the dependent poor that there are important differences between the very poor who manage to maintain themselves without public assistance and those who do not have the resources to achieve even a minimum level of economic independence.[13, 14] For example, negative public attitudes toward mothers who are dependent on AFDC tend to transfer to the mothers and their children and are associated with a sense of failure, strong self-disparagement, and hopelessness.

Occupation, education, income, and place of residence are the factors most often used by research workers in ascribing a certain socioeconomic level to a person. If the unit of study is the family, however, the factors of education and occupation are considered only in relation to the *head* of the family. Seldom is attention paid to these factors as they apply to the wife and mother (unless the father is out of the home), and even more infrequently is the grandparent generation considered. Yet the class characteristics of the wife and grandparents may be important, particularly in relation to the ways in which they may affect child-rearing and family life practices.

Thus, since American society is still somewhat fluid in regard to upward (and downward) social mobility, and since men and women sometimes marry outside their own social class, there are variations in the class-determining factors within each social class as now described. A more sophisticated view of family social class membership is indicated by considerations of this kind.

The question of within-class layers applies also to studies of culture characteristics of racial groups. When Negro-white differences are examined there is a tendency to make insufficient allowance for the many layers of social class groups and the fact that a much larger proportion of Negroes, than of whites, are at the lower socioeconomic levels. Thus, cultural patterns are often described as being "typically Negro," when, in fact they may be more typically lower-lower class than racial. More careful studies, taking variations in socioeconomic level into detailed consideration, are beginning to shed more light in this area.

Another area in which a careful delineation of subcultures may be necessary is in rural, as contrasted to urban, poverty. Moreover, in considering rurality, differences would probably be found in rural-farm compared to rural-nonfarm cultures,[15] in

rural areas close enough to urban areas to be strongly affected, and in rural areas isolated "back in the hills and hollows." The condition of rural isolation with lack of opportunity for escape may tend to "freeze" a subculture with especial rigidity. Then, too, isolated rural areas, with their provincialism, probably carry a stronger regional and historic flavor in their "subcultures of poverty"—if the rural areas actually have subcultures. From the little that is known, it appears that the presence or absence of subcultures in rural areas would be strongly affected by the region itself: its history, geography, and economic situation.

Few studies have investigated the subcultures of the rural poor, and yet the rural poor make up about 15 percent of our total population and 50 percent of the families have incomes below the "poverty line." An exception is a recently published study of a lower class, white religious group in an isolated mountain community in the South.[16] In a number of ways, the cultural characteristics of this group were different from those commonly reported from other studies of the poor.

Limitations of method

Another limitation to research findings concerning the subcultures of poverty is found in the biases imposed on research in general by the fact that findings are irrevocably and inherently tied to the hypotheses and questions on which the study is based. That is to say, the researcher may miss important facts unless he designs his study with pertinent question in mind—or unless he observes certain facts in the course of his study and redesigns it so that he can investigate them systematically. For example, the life styles of the very poor may contain significant elements—such as defense mechanisms of humor, drama, and fantasy—that will not be found unless relevant questions about them are built into the research design. If all the relevant questions are not asked, only part of the total picture of low-income cultures—or whatever other subject is under investigation—becomes available. In fact, it seems as if research has focused chiefly on the weaknesses of the poor rather than on their strengths.

There are also difficulties associated with whether or not data obtained with the selected testing instruments are reliable. A full discussion of reliability cannot be presented here. However, it should be pointed out that special difficulties arise in the use of questionnaires with low-income groups. For example, a low level of literacy frequently obtains in these groups; words and phrases often have different culturally affected meanings from their meanings in other groups; the people questioned tend to respond in the affirmative in order to ingratiate themselves with the researcher; and the testing situation may be far from ideal.[17]

Another limitation to some research findings regarding social class differences also involves a difficulty often arising in other research. This is the frequently misunderstood difference between statistical and practical significance. For instance, many of the findings regarding parental practices of low-income families are derived from comparing their practices and attitudes on various behavioral dimensions such as discipline to the practices and attitudes of middle-class families. While a behavior or attitude may be found to be significantly (in the statistical sense) more prevalent in one group than another, that does not necessarily mean that this behavior or attitude is *characteristic of most of the people in the group*. To take a hypothetical example, 10 percent of a sample of middle-class parents may report that they use physical force in disciplining their children, while 30 percent of a sample of parents from a lower socioeconomic class may report this practice. Therefore, statistical analysis may show that significantly more of the parents from the lower class than from the middle class use physical forms of discipline. However, 30 percent is clearly a minority of a reporting group. In the search for interesting research findings, it is a temptation to report differences as if they had greater practical significance than they do.

Another word of warning. Generalizing from findings about groups to assumptions about an individual is unwarranted. For instance, in discussing the subcultures of the poor, Elizabeth Herzog[12] warns against taking a "cookie cutter" approach to an understanding of *individuals* in the various social

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classes. Not only is every person composed of a cluster of identities related to his many reference groups; he also has his own unique psychological style and genetic potential in making use of and expressing his identities. Although this comment on individual differences is old hat to those in the service professions, a "new hat" enthusiasm—such as the impact of cultural differences—can lead to an over-enthusiastic ritual of hat-changing. Many of the old hats, along with new ones, are needed in efforts to understand the complexities of human behavior.

Hazards of predictions

Not only do such conceptual factors militate against the generalization of findings about groups to conclusions or predictions about individuals, but so do some methodological factors. From the methodological point of view, predicting individual behavior from research evidence derived from groups is a very sticky problem. Although a full exploration of this problem cannot be given here, a few general, nontechnical comments are in order.

In the first place, research evidence pertaining to groups tends to be of more value to persons engaged in the development of general policies and overall programs than to those engaged in work with individuals. This is so, mostly because the bulk of research pertains to *group* trends and tendencies and to likenesses and differences between *groups*.

Transferring measures of groups to individuals is methodologically hazardous for many reasons. An important one is that measurements of groups usually involve the use of averages or of proportions such as one-third of a group. Averages and proportions fail to take into account the variability of individuals. An average group score might be 50, but some individuals might have a score of 5 and some of 90.

Some statistical measures used in research readily yield a measurement of this variability—commonly called the variance or standard deviation. When such measures are available, the meaning of evidence as it may apply to individuals becomes clearer. For technical reasons, contingency analysis (chi-square) is the statistical measure commonly used in studies of attitudes, life styles, values, and behavioral practices, partly because with this technique many group averages may be compared simultaneously. This statistical method, however, fails to provide a ready measure of variability, and thus offers few clues to what the research evidence may mean for specific group members.

A hypothetical example will help to clarify this point. A number of studies may show that a larger proportion of various kinds of middle-class children than of many categories of children from lower class backgrounds get grades of B or higher in school. This is the kind of result that can be derived from the use of a research design which lend itself to contingency analysis. The evidence reveals only general information as to the tendency of these two social class groups to obtain different average school grades.

More specific information can be obtained if the study design and statistical analysis make it possible also to report that groups of middle-class children obtain an average of 2.9 in school grades (when A=4 points, B=3, C=2, D=1), while groups of lower class children obtain an average of 1.7, and that the variability in middle-class groups is 0.4 grade points, while the variability in lower-class groups is 1.3 grade points. In this hypothetical example, one of the helpful pieces of information yielded by reporting the different amounts of variability in the two groups is that the lower class children are shown to be less like each other in the grades they receive than are middle-class children. Therefore, it would be more hazardous to predict a grade-point score of a child from a lower class background from a knowledge of scores for his group than it would be to predict the grade of a middle-class child.

The example is hypothetical, but some research findings actually *do* suggest that the variability in groups of the very poor may in a number of ways be greater than in middle-class groups.

To sum up, research design which permits a ready computation and presentation of measures of variability also permits more specific interpretation of results, especially in their application to individuals. As already noted, much of the research concerning social class patterns tends not to use measurement instruments which readily yield a measure of variability. For the practitioner who is seeking to understand and help individual people, research findings about groups may provide helpful clues but individual diagnosis and treatment approaches are still very much in order.

Sample selection

Passing reference was made earlier in this paper to problems of applying research findings when only small samples of people have been studied. The intricacies of sample selection are far too great to permit a full exploration of this topic here. However,

one point needing emphasis is that the *size* of a sample is generally not so important as the method of *choosing* a sample.

Studies are far more likely to tell something about a group of people in general if investigations are planned in such a way as to provide for a *random* sample. This means that the persons whom one chooses to study are selected so that they fall into the study group by chance and that all the possible members of the larger population about which information is sought would have an equal chance of being selected.

For example, if one were to do a study of public assistance recipients in a certain community, one would choose the subjects at random from all the people receiving public assistance. If sufficient care were given to defining the study universe (in this instance all the public assistance recipients in the county) and to using an approved method for selecting the random sample, a 2- or 3-percent selection from the total group should, in general, provide an adequate study sample. Then if almost all the members of the sample were reached for the investigation, it should be possible to make general statements about the total public assistance caseload *in the community studied* based on an analysis of the findings from the sample, provided other conditions of sound research were met.

Unfortunately, many studies of social class differences fail to adhere to adequate methods of sample selection. People sometimes become research subjects because they volunteer to be included in a research project, or because they live in a certain neighborhood, or because they answer a mailed questionnaire. In such instances, the results of the study may be interesting, but because the subjects are not likely to be representative of a larger group, it is extremely hazardous to apply the findings beyond the particular group studied. Nevertheless, wider applications are frequently made.

Moreover, even if an investigation has been carried out with an adequate random sample in one community, the findings do not necessarily apply to another community, although such applications are frequently attempted. Allied to this point is another. Studies are time-bound as well as being place-bound. Findings for a certain community in 1960, for example, may not apply well in 1965 and very likely even less well in 1970.

Present efforts to understand the "culture of poverty" derive from the best of intentions. But they may lead to dangerous and degrading stereotyping if proper care is not taken in designing and interpreting research. By identifying some areas where precaution is needed, however, I do not mean to intimidate those who seek to understand and use research findings. It is as possible to be trapped by oversophistication as by the lack of it. Although research findings surely have their limitations, they can illumine the work of the administrator or practitioner if both proceed with a spirit of open-minded interest or exploratory application. Although "a little knowledge is a dangerous thing," not using that which we have can be even more dangerous. But the use must be guided by wisdom.

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HELPING MEDICAL STUDENTS FIND THE STRENGTH IN PEOPLE

PAULINE G. STITT, M.D.

A medical student sat, head in hands, lost in thought while he studied the thick hospital record of a teenage girl in an American city. There were the cover sheet, administrative papers, professional histories, "progress notes," laboratory reports, and other entries found in a hospital record, which together usually give a picture of a medical condition, and sometimes, even of a patient.

The student's face was grave.

The preceptor asked the student what was troubling him, and the young man replied, "I can't get over what this record tells, and what this patient shows, and I feel this way over and over again on this home-care service. How in the world do people hold together through these illnesses and terrible life experiences? Why do some people seem to have more strength than others? Are there ways we can help people have strength, or, can we discover what kinds of strength they do have, and then build on them?"

That student, in seeking his patient's reservoir of strength, had touched on one of the most agreeable, interesting, and promising aspects of medical teaching and patient care: The identification of the kinds of strength a patient has, and the deployment of services to reinforce and, if possible, increase that strength. All of his questions were pertinent though at present largely unanswerable. Search for answers to the last two could put new life in medical teaching, and in the practice of the various professions serving people: *Are there ways we can discover the kinds of strength people have, and then build on them?*

The student's questions led to action. He and the preceptor concentrated on strength detection and utilization during the rest of his stay on the service.

Today, enlightened medical care goes beyond treatment of illness and concerns itself, where possible, with prevention. In addition, it is giving increasing attention to *constructive medicine*, medicine which moves forward into the healthier and more positive areas of fortifying and enhancing existing strength and potential. This threefold concept of medical care—treatment, prevention, and constructive service—is applicable to most fields of medical care, and is particularly relevant to family medicine and pediatrics, where dynamic care identifies, and then works with, the vast forces of human growth, development, and adaptation.

When you build a bridge you are as much concerned with banks and abutments as you are with the river. In combating illness or injury the same constructive principle applies. Although at some point you may have to remove an offending agent, real restoration and healing, when they occur, come from whatever strength still exists.

All kinds of strength are usable. In pediatrics and maternity care it is especially rewarding to reach out beyond whatever physical strength may exist, and to locate and build on all the cultural assets a child, his family, and his social group may possess. Furthermore, the child can often be best served through services supplied to his mother or father or his whole family, rather than through exclusive reliance on what can be done directly for him. Thus, effective pediatric care tends to follow the physiologic models of reaching an unborn babe best through the umbilical cord, and an infant through the breast milk.

To help children then, one nurtures not only the children but those who are directly providing them with care. One needs to "help the helpers." This is true of professional "helpers," it is true of communities, and smaller social groups, and it is particularly true in working with the hardest pressed "helpers" of all—the parents.

This made it possible for one woman, in thanking

a clinic for 2 years' service to her children, to say: "Goodbye. The thing I appreciated most is that you folks knew how hard it is to raise children!"

Search for and utilization of what strength the parents have may be particularly rewarding for professional persons working with families who have had to devote strenuous efforts merely to survive. Such people through long experience in coping with problems of survival may have acquired treasuries of potentially accessible strength.

Today's programs for children with cerebral palsy, for example, often use "standing tables" and related devices to enable the children to maintain balance while playing. For ages, little children similarly afflicted have been helped to stand in small wooden barrels, by parents who perceived their children's needs. At first glance, the sight of a child in a barrel has sometimes appalled professional workers, but a closer look makes clear that it is the cerebral palsy that is appalling and the barrels represent an interesting and effective cultural improvisation, later improved on by certain professional modifications.

There are often similar treasuries of strength found in ethnic groups who have accumulated a shared wisdom in coping with life's problems. In working with such groups, it becomes a professional imperative, and a privilege, to search for the power and the glory that carried them through the past and to today.

Professional students and multidisciplinary teams working with people in low-income areas, especially those of minority ethnic groups, are often warned not to apply their own middle-class-value judgments to their patients or clients. This is important. But far more important is the need for the preceptors to be positive and to encourge students to initiate and sustain a systematic search for the strength in the people they serve. This is a straightforward approach to a professional inventory and appraisal of the resources within a situation in which one hopes to be helpful.

Perception of strength is especially helpful if it is "fed back" to the patients, back to those who have shown the strength and back to others who may profit.

Mrs. Callahan found that her youngsters liked nothing better than an early breakfast of hamburger, fried potatoes, and onions when their father came in from his night shift. Student health workers eyed the menu squeamishly. Mrs. Callahan explained the importance of this nutritious meal in the company of a beloved father. As she said: "Good food's good anytime of day—and the kids need to be with their old man anytime they can get a chance."

Mrs. Callahan's recognition of the importance of nourishing not only her children's physical needs but also their good relationship with their father was a lesson with great carry-over value, for the students not only learned from Mrs. Callahan, but Mrs. Callahan herself had the pleasure of seeing that they valued her good sense and remembered and used her ideas later with other families.

In all forms of diagnosis, the view of the patient can vary from observer to observer, each viewer having his own vantage point. This selective perception can provide revelations no single observer could glean. A multiprofessional medical care team may catch glimpses of their patients' rich and varied personal and social resources when each profession is encouraged, or required, to include a presentation of the potential strength seen in the patient and in the situation which surrounds him.

The preceptor's role in preparing students to see the strength in their patients is to see the strength himself. He has to practice constantly to sharpen his own perceptions in this regard and to recognize and encourage such perceptions in his teaching colleagues. Then the teaching team can convey these ideas through example.

Combating cultural shock

Numerous examples could be cited from the writer's experience in teaching medical students in a home medical care service in a large city, where the medical, nursing, and social work professions collaborated in providing home-based medical care to patients living in a crowded, low-income area. A new group of medical students reported to the service each month, and, with instruction and supervision, assumed responsibility for home-based medical care for a number of patients varying widely in age and medical condition.

In addition to the usual adaptation a student has to make on entering any new service in a teaching hospital, these students had to accomplish two other major adjustments. They had to accommodate to the "cultural shock" of sudden acquaintance with modes of life different from their own life experience, and to come up against, and survive, the shocks of their first major encounters with illness in people's homes. Up to that time, the students' experience with illness had been almost entirely with patients safely ensconced in the orderly confines of a teaching hospital, in the midst of impressive equipment and experienced workers.

Disease, disaster, and human suffering are difficult

to meet even in a hospital but can be unnerving when first encountered in a dilapidated hovel where an unkempt, suffering person struggles in misery while frightened members of his family look on in anguish. Even without the illness, the living situation may seem to the student to be more than a human being could endure.

Those in the serving professions must survive too, if they are to be helpful. This is true at any age or stage of professional development. Each professional worker has to be acutely sensitive to his patient's needs and yet stable enough to stand steady for his patient's sake. This is especially important during the early traumatic experience encountered in the professional preparation of future doctors, social workers, and nurses. Nothing must go wrong with the patients—or the students.

Students need challenging experience, but they need mature and understanding help from their instructors, so that what is challenging up to a point does not become overwhelming and permanently damaging. On this home medical service the teaching group found that much support could be supplied through helping the students ferret out the potential strength in every situation.

The medical students found wretched housing and makeshift domestic arrangements confusing and tended to leap to discouraging opinions of people who lived in any degree of squalor. As they reacted to the unfamiliar life-chaos they were encountering, they were apt to be unduly impressed by rigid orderliness, to the point that sometimes they were blinded to other aspects of a home. A distraught, compulsive mother who kept her house "as neat as a pin" (and perhaps without a pin's worth of coziness) often impressed the students as the model mother on the block, but they tended to recoil from occupants of crowded, cluttered, and confusing quarters and thus to overlook whatever strength these people had.

However, the social worker and public health nurse on the teaching team usually managed little by little to bring to view the warmth, the fortitude, the love, and other healthy elements of family functioning often hidden from the students by domestic chaos in which some families were submerged.

The students especially needed help in understanding patients of ethnic backgrounds other than their own. But with help in detecting the strength in each individual they became emancipated from the stereotypes which otherwise would have hampered their functioning as physicians. Then they were able to sense the strength in people and to harness it in ways that made medical care exciting and effective.

An example

The B.G. family helped open the eyes of a number of students. The family consisted of a pair of frail, elderly Negro grandparents, making a home for several small grandsons on a subsistence income. The exact composition of the grandson-group changed from time to time as the grandparents and the boys' father and mother, dividing the responsibilities of child care, would decide which boys needed to be with their father and mother and which might profit most from being at Grandpa's.

Each new group of medical students was apt at first to view the B.G. ménage with distaste. Accustomed as these students were to themselves, their friends, and the representations of family life they had seen in movies, magazines, and other glamorizing presentations of home life in the United States, most of them suffered sharp "cultural shock" when they entered the home of people of different appearance, different household arrangements, and conduct different from what they were used to.

Finding the grandfather, ill with diarrhea, in bed with a young grandson who had a sore throat while Grandma and three other grandsons ate chicken soup 4 feet away at a card table was enough to nauseate one student and make him want to leave the case. Encouraged to hang on and helped to become acquainted with the family through the social worker, the nurse, and the medical preceptor—all of whom kept asking the student at every case conference what strength he saw in the family—the student soon regained his poise. Eventually he became the family's champion, and spent much of his own case-report time pointing out the "guts," "backbone," and ingenious approaches to life he was discovering in this family.

The old grandfather had severe heart trouble and

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The pride of her children reflected on this mother's face indicates that the medical team concerned with their health supervision will be able to build on her maternal strength.

his wife's condition was almost equally precarious. Prognosis for each of them was hopeless for recovery, and poor for long survival. Unsure whether the man and wife realized these facts, the succession of medical students who went into this home worried about what the old people's attitude might be if they did grasp the bleak outlook. The grandfather finally showed them the light. One morning after he had had a close call with a severe heart attack, he used the little breath he could muster to tell the students *his* goals.

He said, "I am thankful we made it through last night."

("We"? himself? he and his wife? he and his wife and the service?) The old man made a sweep of his arm as though he meant all.

"I am thankful we made it through," he repeated. "These are hard times for boys like ours. Things are going to continue to be hard for a long time ahead. The boys will need a lot of help to hold up and be good men. Their grandma and I know we won't be able to hang on much longer, but we figure that every day we live, we're getting them in better shape for when we have to go!"

The medical students who heard that were no longer blinded by the deceptive appearances of domestic clutter that exist when valiant people maintain homelife for five little boys in a rundown flat. They saw the majesty of the situation and allied themselves with it. The medical care they gave that old couple had scope. It dealt not only with the present heart disease, but with helping two old people hang on long enough to give the young a "good start."

The following sequence of student reaction became something of a pattern on this home-care service: initial cultural shock; beginning recognition of strength, further stimulated by selective perceptions of the professional preceptors serving the same family; and finally a flowering into a well-balanced observer, alert not only to pathology, but also to the sound, the good, and the healthy aspects of the family's life, on which professional workers could build their therapeutic and nurturing efforts.

At the end of their month's assignment, students left that teaching service and scattered to their next hospital posts. From many of them, and from some of the units on which they subsequently served—especially the psychiatric service—reports drifted back of the carry-over of this constructive learning experience and of the pleasure and usefulness the students continued to find in the identification and utilization of the kinds of strength to be found in patients and their families.

Feeding patterns

Family feeding, particularly infant feeding, provides other examples of the usefulness of strength perception, and of the importance of respect for cultural patterns.

Among all sorts of human groups one finds highly organized behavior and traditional practices connected with child feeding. Any large American city turns out to be a treasure chest of the world's interesting feeding customs, if one starts looking.

Medical students need to be reminded that infant feeding has been going on since time immemorial and that unless elements of wisdom and understanding had been employed, none of us would be here today. They also need to be reminded that over the years as technical knowledge of foods, nutrition, and infant needs has been changing, other changing factors—sanitation, transportation, food preservation, and food processing—have also had a drastic effect on infant feeding patterns.

In past generations and down through the ages, feeding traditions were developed and passed on from one family to another in the interests of keeping the children alive. Because of sanitary improvements and greater availability of safe foods, some of the old patterns have lost their pertinence. Nevertheless, traditional family feeding methods always deserve thoughtful attention. For example, with the present in-migration to the big cities, and the poor housing arrangements which some of the incoming couples find, diarrheal disease is again a real threat. Therefore, it might be well to encourage the practice of prolonged breast feeding, once traditional among

some ethnic groups. One should risk early introduction of solids and wide choice of food for babies only where there is top-notch sanitation. A medical adviser needs to listen carefully to a family's feeding ideas, select those that are nutritionally, pediatrically, and hygienically sound and use them as the foundation for his guidance.

Patients as teachers

According to Hippocrates, the physician is forever beholden to his teachers. It follows that some of us can never hope to repay those who have taught us the most—our patients. This is especially true in pediatrics and in maternity care, those tradition-rooted portions of medicine where the richest source of learning is the enlightenment derived from respectful observation of the varied maternity and child-care methods which have kept mankind alive through the ages. Among the most instructive experiences can be those the physician has in working with people who have been obliged to get their clues for child care directly from their children. Such people often relate to a baby with the courteous respect other people too often reserve only for adults. If given a chance, they may accurately and wisely interpret their baby's actions and responses to the professional people trying to serve him.

The interplay between such parents and clinic staff members is often a series of dynamic unfoldments. The parents may ask a medical question. To make rational reply, the staff member will seek further individualized information about the baby and question the parents. The parents then respond with their own astute observations—not a pious recitation of something read in a baby book or child-care article, but a clearcut bit of real-life data—"He doesn't like it, Doctor." "Oh?" "No. It scares him." "Scares him?" "Yes. I reckon it slips on his tongue." "How can you tell?" and so on and so on. In thus contributing keen observation and interpretation, the parent is in partnership with the professions serving him and his child.

One woman illustrating this phenomenon was a domestic worker from a Caribbean island who had moved to a large city in the United States. Books were no help to her, although she could read advertisements, warnings, and other brief communications. On becoming pregnant, she sought maternity and pediatric care and utilized both well, but in a rather mechanical way as though to oblige the doctors and nurses. But about the time the baby began to watch and respond to her facial expressions, she developed a whole new maternal approach.

This warm, intuitive mother became a revelation to all who had the privilege of observing the developing relationship between her and the baby and her way of meeting the baby's needs. A physician and group of nursing and medical students were with her one afternoon in the clinic examining room where a defective cabinet hinge always made a harsh sound whenever the cupboard door was opened. The mother stood there, cuddling and patting the drowsy 16-week-old baby. Both seemed partly asleep. Suddenly a nurse opened the supply cabinet and the rasping noise screeched through the room.

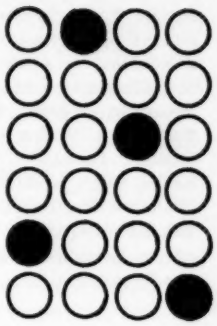
The baby shuddered, clutched his mother's blouse, and looked not at the noisy cabinet but to his mother's face, as though for interpretation and reassurance. He got both. The woman who for a moment may have been as startled as the child, now crooned a gentle, wordless sound, patted her baby, and carried him over to the offending cupboard. There, in a soft whisper, she told the baby exactly what that shocking sound had been.

The baby watched his mother's face absorbedly, relaxed, and sighed. He may not have understood the words, but he got the "music," and the two of them, mother and child, settled down to their own cozy form of clinic wait, but with deepened bonds of mutual understanding.

Further acquaintance with this mother and child over months of clinic care bore out and further revealed the richness of the rapport and the relationship developing between them. All pediatric care was built on this observable strength. Instead of initiating the progressive steps of pediatric guidance in authoritative and impersonal ways, the clinic staff watched for successive stages of readiness in the mother and child and used them in introducing new steps in care. For example, the mother told of the child's pleasure in plucking at her dress buttons and how he "wanted to eat them"; and this report of "precise pincer prehension" told the staff he was already to employ eye-hand-mouth coordination in finger feeding.

Thus, family health care and pediatrics become increasingly interesting and effective when one diagnoses and utilizes the strength in the people served. This strength-seeking approach to medical care has rewards for patients and for the serving professions. It adds zest and new dimension to services for people from depressed social groups, who too often are underestimated as parents—and as people.

TESTING RETARDED CHILDREN FOR DEFECTS IN VISION



ROBERT T. BLACKHURST, M.D.
EDMUND RADKE

About 250,000 mentally retarded children of school age in our Nation are functioning as best they can with uncorrected defects in vision. The very children who can least afford it may well be educationally short-changed because of the handicap poor vision imposes. And at the present birth rate, another 25,000 babies will be born each year who will be classified as mentally retarded and who will go through school with uncorrected, significant defects in vision.[1]

Our estimate of the prevalence of uncorrected defects in vision among these children is based on the result of a program in which 6,158 mentally retarded children were tested for defects in vision. The program was carried on by the Detroit Department of Health in cooperation with the Vision Section of the Bureau of Maternal and Child Health of the Michigan Department of Public Health.

The battery of tests used in the screening included a 20/30 Snellen Test (a test for acuity), a 1.75 plus sphere lens test (a test for farsightedness), and a phoria test (a test for eye muscle balance). Children under 6 years of age, however, were given only the Snellen test.

Standards for these tests have been determined by the Vision Section working with an advisory committee of ophthalmologists of the Michigan State Medical Society. A total of 1,313 children (21 percent) failed the test and their parents were advised to take them to eye doctors (including ophthalmologists, optometrists, and osteopathic eye specialists). According to about 300 records received from doctors, over 90 percent of those examined were found to have significant uncorrected defects in vision. This proportion is consistent with the findings of a larger study completed in Detroit in 1962 based on 2,958 reports from doctors on children in regular classrooms.[2]

A 1964 report by the Children's Bureau on the health of school-age children in the United States estimated that in 1960 about 10.2 million of the Nation's 44 million school-age children had "eye conditions needing specialist care, including refractive errors," and predicted that, by 1970, if the school-age population rises to 54 million as expected, about 12.5 million school-age children would have serious eye conditions.[3] If these defects are not corrected, these children will not be able to develop their full potential, and the problems of the mentally retarded children among them will be compounded by the added handicap of poor vision.

Fortunately, there is a growing awareness of the importance of good vision to good learning.[4-7] The eyes, after all, are the principal instrument for learning.[8] Yet, according to surveys we have taken in Michigan involving many thousands of children, one out of every three will have a defect in vision needing correction by the time he reaches high school graduation age (and even today we are not discovering and correcting all the eye problems of schoolchildren).

Based on a paper presented at the 1965 annual meeting of the American Public Health Association and the American School Health Association.

Robert T. Blackhurst, M.D., left, an ophthalmologist and a surgeon, is chairman of the subcommittee of ophthalmologists, Child Welfare Committee, Michigan State Medical Society. **Edmund Radke,** right, is chief of the vision section, Bureau of Maternal and Child Health, Michigan State Department of Public Health, and is also chairman of the Committee on Eye Health of the American School Health Association.

Because of the success of testing in Detroit, we believe that educable mentally retarded children can be tested for defects in vision with little or no modification of the procedures used with children in regular classes. The vision technicians who conducted the testing in Detroit reported that "the children paid close attention to directions, were cooperative, and were, if anything, even more polite than children in the regular classroom." They also reported that not one educable child was incapable of being tested.[9]

Testing the severely retarded

Obviously, not all mentally retarded children can be tested so easily, but testing procedures can be adapted to the ability of children who are more than mildly retarded, and it is most important that they be tested.

On a recent visit to a class of 14 severely retarded children we found good examples of how even severely retarded children can be tested for defects in vision by observation and by tests adapted to their ability. Moreover, the results of the tests given by a vision technician point out that many mentally retarded children may have undetected defects in vision. A staff photographer accompanied us to the school, and subsequently our department's office of health information produced a film of the proceedings.

On arriving, we asked the teacher in charge to continue her routine so that we might watch the children at work before formal testing began because symptoms of defects in vision may often be detected by observation alone. On this basis, we were able to refer several children.

As we looked about the room we saw a girl who consistently looked under the lenses of her glasses, apparently because she saw better without them. Her unusual conduct attracted our attention: Most children will look through their glasses, at least for close work, as long as they are able to see at all. Because this child apparently could see more easily without glasses, she was referred for care—that is, on the basis of our recommendation, her parents were advised to take her to an eye doctor. (The public health nurse of the local health department follows up referrals to see that something is done for the child.)

The next child we referred from observation had glasses that did not fit properly. The temple pieces bowed out as if the frames had been outgrown, and the lenses were tilted. (The importance of properly fitted glasses cannot be overemphasized for two reasons: Children may not wear glasses that are uncomfortable; and poorly placed optical centers may induce horizontal or vertical distortions that can cause strain.)

The third child we referred on the basis of observation was a boy whom we suspected of having eye trouble because he had his head buried in his work. The teacher confirmed our suspicions that this was his usual behavior. Several explanations were possible, though extreme nearsightedness or subnormal vision were the most likely causes. In any case, he definitely needed the attention of an eye doctor. (A third possible explanation is that his problem was psychological and no defect in vision may have been present. He might have been one of those children who simply wants to get close to things even though

Figure 1.—**By observation the authors knew this little girl had eye trouble. She moved her eyeballs rapidly from side to side, a symptom of nystagmus, and kept her head tilted.**

their eyes are normal—they want to get "inside" a book or close to a drawing.)

We then observed the children at close range. From this observation, we referred a little girl whose eyeballs were moving rapidly from side to side and whose head was tilted. (See fig. 1.) Apparently she had a form of nystagmus, a not uncommon defect among children. In nystagmus, of which there are many types, the eyes may exhibit a vertical, horizontal, or cyclic movement. In addition, there is a form of searching nystagmus in which the movement may be a combination of all three (this is a type often seen in infants with subnormal vision in whom the inability to fixate an object results in a continual searching). It is this type we most often encounter in mentally retarded children. Children with nystagmus usually see better when they look through the corners of their palpebral openings and with both eyes open. As a rule, they may see several lines better on a Snellen chart with both eyes together than they do with either eye individually. The fact that this girl kept her head tilted might have been an indication of more than one defect. If a child consistently looks at objects with his head turned or tilted, or with one eye closed, he should be referred. Closing one eye suggests faulty binocularity.

The next child who drew our attention was a boy whose left eyelid was drooping enough to interfere with his field of vision. He appeared to have ptosis, as this defect is called. Although the left eyelid drooped more than the right, both eyelids appeared to be involved. He used the muscles of his forehead (the frontalis) to keep his eyelids out of the way of his sight. Correction of ptosis requires surgery.

Up to this point, we had referred 5 of the 14 children simply on the basis of observation.

Testing of the other children required more formal methods. The vision technician then used the corneal reflection test. In this test, the technician shines a beam of light toward the child's eyes at a distance of about 30 inches in a direct line between the two. If vision is normal, the reflection from the light falls simultaneously in the center of each pupil. If, however, the child has a defect involving the ocular muscles such as a crossed eye, the light falls in the center of one pupil but off center in the other. This test is well suited for children who are either too young or too immature to cooperate in more elaborate testing.

One boy was referred for treatment on the basis of this test. In his case, the reflection appeared on the pupil of one eye and below the pupil in the other, an indication of hypertropia. (See fig. 2.) In addition, we noticed that more of the sclera was visible beneath the boy's left cornea than below the right, so he obviously had a left hypertropia. In this disorder, any of the eight muscles (four to each eye) used in the vertical movement of the eye may be involved. The doctor must work quite a bit with a child having this

Figure 2.—A beam of light, shone in this boy's eyes by the technician, appeared on the pupil of one eye but below the pupil in another, a sign of the disorder hypertropia.

Figure 3.—One boy who would not speak was given a wooden E which he could turn in the same direction as the E used in the Junior Vision Screener, a test for acuity.

disorder to determine what treatment will be effective. In any case, the light reflection test will verify the presence of a deviating eye that might otherwise be missed in other forms of testing.

The next screening procedure was to test the visual acuity, insofar as it could be measured, of the other eight children. For this test, the technician used the Michigan Junior Vision Screener,[10] an instrument developed to test the vision of preschool children. It employs a Snellen E, which is presented as a 3-legged table in a frame of reference familiar to a young child. The vision technician plays a game with the child and asks him to tell which way the table legs are pointing.[11] This test works well with both normal preschool children and older mentally retarded children.

Using this instrument, we were able to test the other children successfully, two of whom failed the test. Each child was tested at a 20/30 level, first with both eyes and then with each eye separately. Care was taken to see that the method of testing assured that the child understood the test and that communication was established between the child and the technician. For instance, one boy would not speak. To test him, the technician gave him a wooden E which he could manipulate and turn in the same direction as the E in the instrument. (See fig. 3.)

Four of the children responded so well to the Snellen E test that they were then tested with the same battery of tests used with educable mentally retarded children. A stereoscopic instrument containing the three tests (Snellen chart, plus lens, and phoria) was used. One failed the plus lens test, another the phoria.

When all screening had been completed, we found that 10 of the 14 children were to be referred for eye care. This was a higher number than we would ordinarily expect to find.

Using techniques such as those discussed here, vision technicians throughout Michigan will soon be testing children in classes for the mentally retarded. If sufficient attention is given to the kinds of tests administered and to the testing procedures, the skill of trained technicians will ensure a successful screening program.

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The most meager background will do, if the world the child meets can do just that little fancy footwork to be ready for him. If we stay stuck with one favorite color—white, and one favorite style—verbal, and one favorite background—middle-class, we make the love affair between the child and his world the rare privilege of a favored few, instead of the prized outcome for all.

James L. Hymes, Jr., Education Professor and Director of Nursery School-Kindergarten, University of Maryland, to the Association for Childhood Education International Conference, New York, 1965.

A REGISTRY ON CHILD ABUSE

WILLIAM H. IRELAND

On July 1, 1965, the Illinois Department of Children and Family Services established a central registry of abused child cases, under the mandate of the State's new law requiring physicians and other practitioners of the healing arts to report all cases of suspected child abuse. This has made it possible to get a clearer picture of the nature and extent of child abuse in the State. For example, in the first 9 months of its operation, the registry received more than twice the number of reports of child abuse as had been anticipated. The bulk of the reports came from the Chicago area, but cases were also reported in all eight geographic regions in which the department has regional offices. "Beating" was by far the most frequently reported type of abuse.

Thus, a central registry of cases of suspected child abuse is comparable to the communicable disease registry commonly used in the public health field. Incidence of communicable disease, subclassified by type, locality, time of occurrence, and population affected, is indispensable to health authorities in developing and coordinating measures to control disease. The gathering of similar data on the incidence of various types of social malfunctioning could be useful in designing effective methods of control. A central registry on child abuse is a step in this direction.

Ideally, a central registry should make possible (1) definition of the problem; (2) the development of a logical program for its control; (3) the planning of recording methods and procedures for the administration and analysis of the program; and (4) the evaluation of the program. Obviously, these functions cannot be accomplished simply nor simultaneously.

How a central registry will operate depends on a variety of factors, but basically it must be related to the law governing reporting of suspected abuse. The points in the law which are relevant to the operation of a registry are: (1) What shall be reported? (2) Who shall report? (3) To whom shall they report? (4) When shall they report? (5) What shall be done upon receipt of report?

In Illinois, the Child Abuse Act, passed by the 1965 legislature, requires hospitals and physicians, surgeons, dentists, osteopaths, chiropractors, podiatrists, and Christian Science practitioners to report on children whom they have cause to believe have suffered injury, disability, physical abuse, or neglect inflicted by other than accidental means. The reports are to be made immediately by phone or in person to the nearest office of the Department of Children and Family Services and, also, in writing within 24 hours after examination of the child. Reports may also be made to the local law enforcement agency, but, if this is done, the Department of Children and Family Services is to be so informed. In addition to maintaining a central registry, the department is required to investigate the cases reported, to offer protective social services to prevent further abuse or neglect to the child, to safeguard his welfare, and to preserve and stabilize family life whenever possible.

The Illinois Department of Children and Family Services provides statewide protective services through 8 regional offices and 25 district offices of its Division of Child Welfare. The responsibility for the operation of the central registry on abuse resides in the Department's Division of Planning, Research, and Statistics. Through the coordinated planning of these two divisions, the reporting procedures, service program, and central registry were in operation on July 1, 1965, the first day the act went into effect.

The reporting system

The central registry records only those cases reported by a hospital or members of the professions designated as responsible for reporting under the law.

William H. Ireland has been with the Illinois Department of Children and Family Services as chief of the Division of Planning, Research and Statistics since 1964. Previously, he spent a total of 18 years as director of welfare councils in Seattle, Wash., and in Akron, Ohio, and on the staff of the United Fund of Greater St. Louis.

In addition to the information required to be reported, its records contain certain items that assist in observing compliance with the law, and some characteristics of the child, the family, and the abuse situation.

The registry is tied in with the child welfare division's regular service accounting system so that additional information about cases receiving service or care beyond the initial investigation may be obtained. The registry's procedures are designed to speed the forwarding to it of all pertinent information about each case at the time the information is obtained.

When a child welfare worker in a regional or district office receives an oral report of suspected child abuse from a medical practitioner or hospital, he records the information on a duplicate form, a copy of which is retained in his office and another copy sent immediately to the central registry. The information in this first report includes the date and time the oral report was received; the name, address, sex, and age of the child; the names and address of the parents or persons having custody of the child; where the child was first examined; the name, address, and telephone number of the reporter; the date the child was brought to his attention and by whom; the nature of the child's condition, including any evidence of previous injury or disability; the child's present whereabouts and the reporter's immediate plan for him; the types of abuse suspected; the person or persons presumed to have inflicted it; and the worker's judgment as to the seriousness of the immediate situation.

The written report from the practitioner or hospital is made on the practitioner's own letterhead or on a form provided to hospitals by the department. The original copy is retained in the regional or district office to which it is sent and a facsimile immediately forwarded to the central registry.

As soon as a case is reported to a regional or district office, an investigation is made, and, if necessary, service to the family and child initiated. After the initial investigation the worker sends a brief report about the family to the registry. Because this type of investigation is a major service responsibility, the worker is allowed up to 10 days to report on it.

The worker's followup report to the registry includes, besides the necessary identifying data, information on the composition of the family or household, including the marital status and ages of the heads of the household; the names, sex, and ages of the children and their relation to the heads of the household; the names, sex, and ages of others living in the household and their relationship to the child; the names, sex, ages, and whereabouts of any of the children's siblings who are not a part of the household; whether the allegation of abuse was admitted by anyone in the family and if so by whom; the parents' or caretaker's explanation for the child's condition; and whether or not there is a history of any previous instances of child abuse in the family. The reporting form also includes space for additional remarks.

The worker's followup report also indicates whether or not further service is to be provided the family or child by the department or through other agencies. If so, further records and service accounting are made in the same manner as in any child welfare case. In Illinois, information on all child welfare cases, whether public or voluntary, is kept by the department's statistical section in a central index of child welfare services.

In the interest of brevity, the reporting forms for the central registry of child abuse cases have been made especially succinct. For example, the term "abuse" is used to cover abuse, neglect, or injury. The term "suspected abuse" does not appear on the forms although it is understood that there may not have been a determination of actual abuse at the time of the report.

Use of information

Department staff members in the regional or district offices may contact the central registry at any time to learn whether or not a child has ever been reported for abuse. Since the central index on child welfare services and the central registry on child abuse are closely correlated, the same inquiry may elicit information on whether or not the child or family is being or has ever been served by the department or any of the voluntary child welfare agencies licensed by and reporting to it. This optional procedure may be interpreted as a diagnostic aid or sim-

ply as a means of reducing duplicate efforts. It is diagnostic in the sense that a child or family that has been reported previously on suspicion of abuse can be identified and the worker directed to the source of more detailed information. Even if no previous report of abuse has been made on the family, a cross check with the index on child welfare services will reveal whether the family has previously been served by a child welfare agency and so may make it possible to get further background information to assist in diagnosis or service.

Persons outside the department, including physicians or law enforcement agencies, do not have direct access to the central registry, since the same principle of confidentiality of information applies to it as applies to all department case records. However, persons who have reported, or are contemplating reporting, a case can receive helpful diagnostic information and assistance through consultation with the child welfare worker in the region or district to which the report was made. This direct consultation improves interprofessional relationships. In addition, it saves the inquirer a long distance telephone call to the State capital since the nearest office of the department will probably be in his own community, or, at the farthest, 35 miles away.

The Division of Child Welfare also investigates complaints of neglect or abuse coming from sources other than those named in the Child Abuse Act, and provides whatever services seem indicated. Such cases, however, are not entered in the central registry unless a medical examination of the child is made and injuries reported.

In short, the design and operation of the central registry on abused children in Illinois takes into account the fact that it is established by and operates in accordance with the law. While some minor adjustments in form design and procedures, shown by experience to be needed, are now being made, the basic operations will remain the same.

The results

Though the central registry has been in operation only a few months, its usefulness has already been demonstrated. It has alerted workers to possible duplicating efforts in a few cases, but this clearing feature has been of lesser importance than the epidemiological function, possibly because of the short experience. There has been no evidence of the "shopping phenomenon"—taking an abused child to a different hospital or practitioner each time he is injured. Again, this may be because the registry has not been in operation very long.

There is, however, indication that those who are required to report suspected abuse under the act are doing so. In the first 9 months, 363 children—200 boys and 163 girls—were reported as suspected victims of abuse. Nearly 90 percent of these reports were followed up by written reports.

The majority of reports, 302, came from hospitals. In addition, physicians reported 51 cases from their private practice. Other sources accounted for 10 cases.

The types of abuse suspected were: beatings (221), fractures (48), malnutrition (47), burns (33), and "other" (60). Under "other" were stabbing, neglect, lacerations, poisoning, sexual assault, gas inhalation, and failure to administer medications. Type of abuse was not reported in 12 cases.

The persons suspected of the abuse were: father (109), mother (136), stepfather (21), stepmother (11), sibling (4), and "other" (73). Under "other" were babysitters (21), relatives (14), neighbor (7), foster parents (4), and miscellaneous and unspecified (27). In 46 reports, no suspected person was noted.

Severity of the child's situation was indicated as "emergency" in 42 cases, severe in 89, moderate in 161, and not reported in 71.

The children reported as abused ranged in age from under 6 months to 16 years, but the great majority, 247, were under 5 years of age; 99 were under 1 year, including 59 under 6 months.

Since the passage of the Child Abuse Act, the department has received numerous inquiries from the community about how well the act is working. These could be—and have been—answered promptly with facts on the number and primary characteristics of cases in the central registry. If need be, the number of children reported to date, sex and age distribution, source of reports, types of abuse, and by whom the abuse is presumed to have been inflicted can be tabulated daily.

Thus, the central registry assists in alerting the public to the nature and extent of the problem of child abuse in the State. It is dependent upon and serves physicians and other health practitioners, as well as the workers in the Department's Division of Child Welfare, who bear the responsibility for protection and service to children and their families. Finally, it provides a base for indicating the incidence of child abuse, further defining the problem, and aiding in developing and analyzing a program to deal with it.

a schoolteacher in a child welfare agency

EMMA SHIEFMAN

For many years school systems of most large cities have employed visiting teachers or school social workers because they recognize that there are aspects of a child's development which, though not the school's direct concern, may directly affect his school performance. In contrast, scarcely any social agencies, other than institutional care agencies, employ teachers. The Detroit Foster Homes Project, my employer, is an exception. Sponsored by the Merrill-Palmer Institute of Human Development and Family Life with a grant from the National Institute of Mental Health (5R11–MH–01551–03), the project was set up to demonstrate that children who have lived in many homes, who have been subjected to marked family disorganization, and who show disturbed behavior, can be placed and kept in "highly reinforced" foster homes. Douglas A. Sargent, M.D., is its director.

My first contact with the project was as an independent tutor for one of its boys. This assignment grew into a staff role as educational consultant and therapeutic tutor and member of a team which includes caseworkers, group workers, psychologists, and a psychiatrist.

There are five fundamental reasons for a social agency working with children to have a teacher on its staff. They are:

1. The child's most important relationships outside the home are in school, for there he succeeds or fails, reveals his mental health or emotional disturbance, as the adult does in his occupation.

2. A deprived child with emotional problems is extremely prone to develop learning problems which, in turn, lead to additional emotional problems.

3. In school and in tutoring, a child may show a side of himself he does not show at home or in social work contacts. Sometimes the teacher or the tutor uncovers clues to difficulties which are helpful to the social worker in working with a child. For the child who is too old for play therapy, the tutoring session often serves the same function. It may seem silly to him to talk about himself, but it does not seem silly to talk about people in stories.

4. The emotionally disturbed child who learns with the help of a social agency's tutoring and school program acquires strength for meeting emotional problems. The sense of mastery which successful learning brings may be the first feeling of success for a child who has known only failure and rejection. This feeling may give him his first reason for believing that conditions can change, his first clue to an understanding of his environment. The most important result successful learning offers such a child is the ability to use language with which to express and identify his feelings and, so, to work them out in less physical and more mature ways.

5. If the school's environment is benign, it can foster changes; if hostile, it can undo months of work by a social worker. In either case, it is an environment that can be changed by one familiar with the organization and operation of the school. A skillful teacher can influence other teachers and administrators, work assignments, and special activities.

Since the project began 4 years ago, it has placed

15 boys (10 Negroes and 5 Caucasians) in "highly reinforced" foster homes and has provided 7 with therapeutic tutoring in language skills, with promising results.

Three case histories

The case histories of three boys—Allan W, Keith C, and Chuck T—who have been tutored for over a year show how progress in overcoming learning problems can help overcome emotional problems in some children.

Deserted by his mother when he was 6 months old, Allan W was in his fifth foster home when tutoring began 2½ years ago when he was 8. Although of normal intelligence, he was unable to read and was in an ungraded class. He was a small Negro boy, full of fears and suspicions, and troubled by enuresis, headaches, stomach cramps, rashes, and nausea. He could not be restrained during lessons. His psychiatric evaluation said in part: "He shows an impulse-ridden character in a child who has been extremely deprived and neglected. His capacity to relate to people is impaired."

An unfavorable foster home added to Allan's troubles. His foster mother was weak, cold, and rigid. She could not tolerate his vile language, for instance.

But Allan got intense gratification from the one-to-one relationship of the tutoring, for in tutoring he could accept unsolicited bounties such as complete acceptance by the tutor more readily and could open up more easily than in the more threatening social work interview. As our relationship deepened, I found he has searching curiosity, playful fantasy, and an artist's eye for details. He developed pride in reading as he mastered the skill. His enuresis was controlled under the guidance of the social worker, and his psychosomatic ailments diminished. He was moved to a 2B and then a 2A class.

A year and a half after tutoring began, Allan met a challenge that might have been crushing. His foster mother became ill and used her illness as a pretext to give him up. Allan showed great strength in making the change to a new home, strength which, I believe, grew out of his gratification in the tutoring relationship and his pride in reading. Fortunately, the new home is much better for him: The mother is strong and firm, and there are two other adopted sons near Allan's age.

The change of families brought a change of schools. His first was an inner city school with large classes and overworked teachers; his new, a beautiful building in the suburbs. Classes are small. When Allan enrolled, conditions were nearly ideal: The principal was elderly and compassionate, and his teacher was young, pretty, and very skillful. In this environment Allan grew as never before. He became a member of the group, a compassionate leader, the third best reader in the class, and the best friend of the best reader, a white boy. He grew more independent, could tolerate disappointments, and could be trusted to remain after school for special activities. He became protective of his younger brother and adoring of his older. He even changed physically; he looked straighter, larger.

Allan was doing so well we began to plan to end tutoring. But what the school gives it can take away. Conditions changed for Allan with a new teacher and a new principal. The new teacher was in her first position and faced a very difficult class. The new principal had his hands full replacing a dearly loved woman (who had retired) in the only truly integrated school in the community. At first, he seemed more concerned with running an efficient school than with the problems of individual children. These changes upset Allan. He got into a fight, and the principal threatened to expel him (an action which would have forced us to remove him from his foster home).

Through the strenuous efforts of almost everybody from the agency, the situation was smoothed over. With our help, his teacher gained confidence, and Allan grew to love her. But 3 months later she moved away; Allan has had two more teachers since she left, the second, a no-nonsense type. He has been in fights and has even run away from school. The principal has again threatened to expel him, and again we had to step in with all our resources.

Nevertheless, Allan seems to have enough strength to live through these problems and to grow. He has so completely identified himself with the agency's goals that he talks of what will happen to him when he is in high school, and has even mentioned college.

Allan's tutoring ended last June, though we planned to resume it if necessary. But in September, his principal assigned him to an experienced, sympathetic teacher under whom Allan is doing very well. My only contacts with him now are on occasional visits to the home to bring books or a gift for a special occasion. He reads nearly every book I bring him.

* * *

Keith C, another boy who has received tutoring for a year or so, had been brutally treated by his psychotic mother. When I first saw him (he was 10), he almost completely lacked expression and language, though he is of average intelligence. He never asked questions, would only answer yes or no, and would shy away from other people. Yet he seemed strongly motivated to learn, as though he needed answers to the questions he did not dare ask.

Last fall, after I discussed Keith with her, his auditorium teacher let him read for the part of "an echo of President John F. Kennedy" in a play to be given for parents. The first time I went over the script with Keith he didn't know at least 50 words and couldn't pronounce others. But he practiced at home, with me during lessons, and in long sessions on my dictaphone. He got the part. After the program, Keith told

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Emma Shiefman, who joined the staff of the Detroit Foster Homes Project as a tutor and educational consultant 2 years ago, received her training as a remedial reading teacher at the reading clinic of the Educational Psychology Department of Wayne State University. Previously, she had spent nearly 20 years in the field of early childhood education—as a teacher in Detroit's public kindergartens and as a preschool teacher and director in various types of nursery schools.

me, "I was a little bit nervous, but not a whole lot. I thought I sounded like him [President Kennedy]."

Keith's principal says of him, "He's a different child now. He even looks different." I agree. His personality has become more open; he doesn't seem so confused. He asks questions (still not the ones that really bother him), and he is able to talk a little about his feelings with his social worker.

* * *

Chuck T, who also started tutoring about a year ago at age 10, was infantile, narcissistic, and unwilling to accept reality. His teacher said he sat in class like a vegetable, never trying.

One day, a few weeks after tutoring began, when I brought Chuck to my home for a lesson, he saw the dictaphone and seemed interested in it. As he had been to the circus the week before, I suggested to him that he use the machine to tell me about the show. We pretended it was a radio interview—"We have a young man here . . ," I said, which delighted him. We transcribed his dictation in large bulletin type, cut out suitable pictures from magazines, and pasted them into a book. He dictated two other stories like the first, and we bound all three in a book, which we titled "Places I Have Been." His foster mother and foster brothers talked to him about it; his teacher let his classmates read it. Their interest made him very proud. It became the first book he read with interest.

From then on Chuck showed interest in reading and in a few months was reading at about his grade level. But he still did no other school work. About 9 months after tutoring started, he seemed relaxed enough with his foster home, his teacher, and me for us to pressure him to perform better. His teacher and I enlisted the help of his foster mother to make sure he prepared for his weekly spelling tests. He responded favorably and soon was making A's on these tests.

Chuck was recently adopted by his foster parents. His mother is taking over much of the school contacts and supervising all the homework—reading, literature, spelling, writing, and social studies. I am still tutoring, and Chuck and I will soon move into arithmetic and science.

Changes of environment

Changing the school environment can mean the difference between success or failure in some cases, the project has found. A child may be in the wrong school, have the wrong teacher, or be in the wrong grade. It is not often feasible to change the teacher, but a change can be made in the school or in the grade.

Take the case of Joe R, now age 13. Joe had attended a class for the mentally retarded with much younger children in his neighborhood school with little progress. We changed him to another school which had special classes for mentally retarded boys his age, including shop work and physical education. His behavior and achievement have improved greatly; he has become an outstanding student, and has even served as a student assistant.

For Paul A, a grade change made a great difference. Paul was not doing well in an "honors" class in which he had been put because it was the only available alternative to the regular class where his behavior could not be tolerated. The teacher in the honors class was a strong and kind man.

We moved him back one grade, but kept him in the honors class for his nonacademic subjects. Under this arrangement, he kept up with his school work, and his behavior improved by being with the serious students in the honors class. Unusually motivated, he has made so much progress in tutoring sessions that we have moved him back to the honors class full time. He attended summer school in 1965 and has been keeping up with the class since.

Sometimes we can work a change in the school environment merely by supplying different teaching materials. One of our most difficult boys, John D, who was having trouble staying in a special class for emotionally disturbed children, now practically races to school each morning because he finds the programed instruction recently introduced to his class so stimulating. For the first time, this boy is working on his own.

The school environment may be changed by helping the teacher change her attitude toward or her way of handling a child. Although there are formal conferences with teachers and principals, most of my meetings with teachers are short and casual—but frequent. When a teacher and I meet, I pass on background information about the child and listen to complaints sympathetically. If all goes well, we become a team to help a child move along in school. Besides helping teachers, when necessary, I take steps to open up opportunities in special school programs such as the band and the safety patrol which may help our boys find success or recognition.

The case histories I have related seem to say that everything good has happened to these boys happened in school or in the tutoring session. Obviously, that is not true. Skillful caseworkers, group workers, and psychologists helped move these boys to express their feelings, to understand themselves, and to change. In addition to exchanging ideas and records, teachers and social workers plan educational strategy as a team, and when the project assigns workers to a boy's case, his educational adjustment is one of the first aspects discussed. The point I have tried to make is that progress in learning and improvement in the school environment through the work of a teacher on the agency's staff created conditions under which the professional social worker could be more effective.

an essay review . . .

A NEW THEORY OF DELINQUENCY? IT'S ABOUT TIME!

FRITZ REDL

Distinguished Professor of Behavioral Sciences
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"Family of Outcasts: A New Theory of Delinquency" by Seymour Rubenfeld* is easily the most exciting book written about delinquency for a long time. Before you tackle it, however, you should know what you are in for. When the author says this is a "theory of delinquency," he means what he says. And if you think you are going to get a bag of trick prescriptions to help you handle "Junior" after he swiped somebody's wallet, or to run a delinquency prevention program on a shoestring, you will be disappointed. In fact, anybody who is still looking for some quick means of preventing something as serious as delinquency should read the last few pages of this book. They contain the most sobering warnings against underimplemented, spray gun solutions for the problem of delinquency that I have ever seen put into such a short space.

The reason I wax so enthusiastic about this book should be made clear, although I cannot in a few summary paragraphs here do justice to the full content and complexity of the author's arguments. After all, he had a whole book to make his points.

One of the great merits of this book is that it takes seriously the silly split between the sociologists and anthropologists—at least some of them—on the one side, and, on the other, the clinicians, especially the psychoanalysts and all others who are still convinced that there is something to personality theory after all.

I fully agree with the author that we have dallied too long in an obsolete either-or stance. Here are his points:

1. Some sociological research has been too one-sidedly focused on an oversimplified "opportunity theory"—as though everything that ever makes a youngster delinquent could be reduced to lack of money, girls, and jobs, or to the anger about blocked upward mobility, socially and economically. And even more, some sociological writings even breathe downright hostility toward anything that is even remotely "psychiatric" or tries to remind people that kids do sometimes have problems before they want girls, cars, or money, that some degree of "pathology" exists in every level of social caste or class, and that all adolescent delinquents have had a childhood behind them, too.

2. Clinicians have indulged for too long in an exclusive reliance on "libido theory" alone, without recognizing the advances of ego psychology. Though he does rap sociological knuckles for exaggerating this point and for making strawman enemies out of the discards of the psychoanalytic past, Rubenfeld tells us in no uncertain terms that we cannot continue to avoid coming to terms with the sociological and culture-anthropological findings.

It seems to me that the difference in the way the two theory-camps "discommunicate" with each other is an interesting issue in its own right. I am impressed with the wrath against anything psychiatric or even remotely case-history oriented in which at least some of the opportunity-theorists indulge. The personality and clinical camp, on the other hand, seems to be accepting, rather than fighting, sociological data and theories, but avoiding coming to grips with them. In fact, most of what sociologists have taught us is by now so well accepted by persons trained in personality theory such as residents in psychiatry that I am constantly amazed at finding all that stuff about class in their own diagnostic writeups, without any apparent awareness on their part that it has been smuggled in by the sociological backdoor and has not always been part of psychiatric lore.

Professional blinders

Some of the excitement in reading this book comes from watching one who is thoroughly familiar with and acceptant of both sociological and psychiatric fields arguing against both sets of blinders, and in a way which could only be done by somebody who has thoroughly studied and has had experience of his own in both areas. However, I suggest that readers who are eager to get at Rubenfeld's "new theory" start with page 183 or even page 234, and read the rest afterward. The author engages in a most scholarly battle with

*Rubenfeld, Seymour: Family of Outcasts: A New Theory of Delinquency. The Free Press, New York. 1965. 328 pp. $5.95.

practically everybody who ever said anything in either field, with fascinating arguments and plenty of documentation, but it takes him a while to get to what he himself really has to say—and that is plenty!

Reweaving needed

The major challenge of this book is its insistence that a new reweaving of theories is what is really needed. Says the author in effect:

- Let's stop talking past each other and hanging on to obsolete either-or issues.
- Let's not only bow to each other's theories and grant generously that maybe the other guy also has something worthwhile to hang on to, but let's also see whether we can really weave the best of personality theory and clinical experience together with some of the more pungent findings of sociocultural research.

In his own weaving job, it seems to me that on the clinical side of the fence Rubenfeld picks up most clearly where Erikson [1] left off, while on the sociological-cultural side he relies not so much on one focal theorist, as on a whole slew of them. Maybe Merton [2] and Parsons [3] stand out, but all the others, including those who got their knuckles rapped in the previous section, such as Cloward and Ohlin,[4] are respectfully drawn upon.

And now comes the point in discussing this book where I am in for serious trouble. Naturally I became curious, as any reader will, by the time I reached the chapter containing Rubenfeld's own theory, to find out what a "new theory" would look like. However, I find it totally impossible to do justice to what I found in less space than the author had for his job—which was 120 pages! All I can try to do is to give the flavor through excerpts. Anything else would be a naive oversimplification—the very thing this book so bravely fights against.

Under the heading of eight "psychocultural propositions," Rubenfeld describes his agreements with and differences from other researchers and theorists. Then he launches a description of his "paradigms" which contains the major part of his psychocultural weaving job. These are based on what he describes as four "psychocultural processes" which may lead to delinquency, ". . . producing young norm-violators who are neither 'sociological' nor 'psychological' delinquents." Such delinquents are " 'normal' in their respective subcultures. They may even evince psychiatric symptoms to lesser degrees than some of their conforming (but self-discontented) peers. The latter may be symbolizers while the delinquents may be externalizers."

Each of these processes, as described by Rubenfeld, "is introduced by a consideration of a particular set of sociocultural constraints, operating at one of four social levels—LL [Lower Lower], UL [Upper Lower], LM [Lower Middle], or UM [Upper Middle]." Thus he prepares the reader:

> Personality adaptations of some people to the set of constraints affecting their class subculture are indicated. Family relationships and childhood experiences which follow from these adaptations are then considered. The effects of these relationships and experiences on prospective delinquents are also discussed. These personalized consequences are then carried through to description of four different kinds of identity crises, each crisis accompanied by different reasons for delinquency—different pressures, that is, for deviance.

Obviously from here on no line of the author's story can be omitted without giving a false impression of the whole. All a reviewer can do is to give the flavor of some of the passages, hoping that they might induce the reader to run and see for himself. However, it does bother me that Rubenfeld sticks to the somewhat antiquated Warnerian [5] categories of LL, UL, LM, UM—but then, after all, he can't really be expected to start afresh with everything that needs reformulation.

Some excerpts

Here are some tastes of his discussion of "Process IV":

> Some UM [Upper Middle] people disregard their own worth in their slavish devotion to the ideology of success. They believe that they are nothing other than what the world says they are. Consequently, they are driven to acquire adulation and power in their interpersonal relationships as much as in the success symbols they seek. They are vain, exploitative, and insensitively self-serving marriage partners and parents. Often, they want to be worshipped by their marriage partners; and, often as not, this desire is defeated by private guilts and inadequacy feelings, stemming from developmental experiences which predispose them to a feverish pursuit of success.
>
> The UM delinquent of this fourth process is a cynic who has had so many articles of faith traduced that his youthful capacity for devotion has failed. . . . His parents are thralls of success; they believe in power and status. They have exaggerated the significance of opportunity as a value and have oversimplified it to mean opportunism. They translate individuality into careerism, and initiative and industriousness into ruthless self-service and exploitation.
>
> . . . The Process IV youth may present the same callow and self-indulgent view of life's purposes and of relations with others. But he will do so in a gross, adolescent way, "with a bark on," and without the superficial niceties of manner and the pleasantries with which his parents have learned to decorate their secondary relationships.
>
> Underlying this boy's suspension of belief lies a history of betrayals and bad faith by his parents toward some of his most essential feelings about himself. His delinquency is a flight into a negative identity from his scorn for a beginning ideological commitment, essential to a resolution of the identity crisis. Though his scorn for new commitments merits respect on its face, it also masks the backward-looking, fearful tenacity of an insecure child.

And, in summary of several points made under the heading of "Delinquency as a Social Protest—A Résumé":

> Each delinquent type that I have discussed is in some way aware of the cultural adversities besetting him and is directing his efforts against them; he is not just responding in terms of the regressed impulses and restricted relations bestowed on him by these adversities. In each process, for example, a negative relation that the dominant classes hold to the class level in which the process occurs may be specified; one can also specify behaviors by which the delinquent seems to symbolize his rejection of the relation that the normative order is in a sense forcing between him and itself.
>
> In Process I [Lower Lower], a lack of relatedness among members of marginal groups results in an infantile character formation in youth which strains toward unlimited power and gratification. The destruction of character was initiated by ostracisms. . . .
>
> In Process II [Lower Middle], a rebellious mother's son shares and suffers from a subcultural resistance to male authority. The relation of dominant groups, in the European peasant origins of this process and in our contemporary society, to class level involved is one of exploitation for economic advantage.

The relatively favorable position of American industrial labor does not detract from the basic consideration that, as Fromm says, "the employer has bought the services of the worker, and however human his treatment may be, still commands him, not on a basis of mutuality, but on the basis of having bought his working time for so many hours a day. . . ."

Delinquency is an adaptation to current realities to be sure, but it is a half-truth to maintain that this quality is its sole, most significant aspect. Adolescence grants freedom to know and act against an unfavorable truth; but childhood has bound some to personal legacies of untouchability, servility, inferiority, alienation. They are not only subjects acting against a reality inimical to their interests, but they are also the objects of that same reality. It is probably this duality which sets off so much of the theoretical controversy in delinquency studies, and that has, I suppose, prepossessed this writing. In fact, it may be said that this theory differs from others in that it takes into account both resentment and rebellion as necessary conditions in delinquency. Social theory stresses delinquency as protest; psychological explanations, generally dwell on manifold clinical forms of resentment in delinquency. This theory maintains that much delinquency is generated only by the dialectical tension between resentment and rebellion. If either is predominant, the inner dialectic disappears, and the deviance that emerges is something else, not delinquency. Without conscious rebellious impulses the resentful individual displays clinical symptoms. If the force of resentment were much weaker, many delinquent youth might adopt the more positive ideologies and actions of social and political protest movements. The truth . . . lies somewhere between.

There is no question in my mind that Rubenfeld's "new theory of delinquency" will elicit a wide range of excited responses. There will be many disagreements on subissues or on facts, there will be sharp criticisms on theoretical and conceptual grounds—there may even be questions raised as to whether this really is a "new theory," or whether it is rather a challenge to develop one.

I myself could find raising questions under any one of these points worthwhile, but have neither the space nor the time in which to do it. And after all, why start criticizing a new theory? Let's first be happy and overjoyed that we have one to criticize! It *is* about time!

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[1] Erikson, Erik H.: Identity and the life cycle: Selected papers. International Universities Press, New York. 1959.

[2] Merton, R. K.: Social theory and social structure. The Free Press, Glencoe, Ill. 1949.

[3] Parsons, T.: Social structure and the development of personality: Freud's contribution to the integration of psychology and sociology. *Psychiatry,* November 1958.

[4] Cloward, R. A.; Ohlin, L. E.: Delinquency and opportunity: A theory of delinquent gangs. The Free Press, Glencoe, Ill. 1960.

[5] Warner, W. Lloyd; Lunt, Paul: The social life of a modern community. Yale University Press, New Haven, Conn. 1941.

book notes

THINKING WITHOUT LANGUAGE: psychological implications of deafness. 'Hans G. Furth. The Free Press, New York. 1966. 236 pp. $6.95.

The basis of this book is a series of 12 experiments involving nonverbal procedures in various aspects of intellectual behavior in deaf and hearing persons from preschool age to adulthood. From comparisons of the performance of deaf and hearing persons in the experiments, the author has developed an "experiential deficiency" hypothesis that conventional language, as a specific mode of thought, is neither necessary nor uniformly helpful in the development of thinking.

Defining thinking as "any behavior specifically related to human intelligence," the author maintains that the process of thinking and the use of language symbols are separate. When we insist that they are not, he maintains, we add to the deaf person's handicap.

The author's plea for a nonverbal teaching method is not new, he points out, nor without a following as the current interest in the Montessori methods illustrates. In his opinion, if educators could accept the idea that thinking "is foremost doing, acting, behaving, or internally operating" and not just knowing the right word, and if they could agree that "education should primarily teach and develop thinking according to a child's optimal potential," they could "more readily seek nonverbal teaching methods, particularly in cases where linguistic skill is retarded or absent."

THE SHAME OF A NATION. Philip M. Stern and George de Vincent. Foreword by Vice President Hubert H. Humphrey. Ivan Obolensky, Inc., New York. 1965. 182 pp. $5.

The poor of the Nation—migrant workers, unemployed coal miners, small farmers, slum dwellers, and poor and lonely old people—are the subject of this "photographic essay," composed of photographs by George de Vincent and case vignettes by Philip M. Stern, revealing the meaning of poverty to the persons enmeshed in it.

The real shame of poverty in the United States, Mr. Stern maintains, is that "an increasingly affluent society has forsaken its poor: ignored or excluded them, lost sight of their needs."

Mr. Stern protests against the way the poor are treated by the public, or "rather, mistreated." He points out that special investigators of welfare departments may police the lives of welfare recipients, large families—usually the poorest—are excluded from public housing projects, a million people are not covered by minimum wage laws, and one out of five workers are not entitled to the benefits of workmen's compensation.

If the poor are to break the bonds of poverty, Mr. Stern asserts, they must have not only education and training, but also a "voice." Granting that it will not be easy to find leaders from among the poor to serve as their voice, he called for efforts to educate the poor

to the "*techniques* of protest"—protest to "arouse the American conscience and shape the national will."

TOMORROW'S PARENTS: a study of youth and their families. Bernice Milburn Moore and Wayne H. Holtzman. University of Texas Press, Austin, for the Hogg Foundation for Mental Health. 1965. 371 pp. $7.50.

How high school students view society, parenthood, child-rearing practices, and education is greatly affected by the education of their parents, and their mental health can be correlated with the socioeconomic status of their parents, the authors of this report of a 10-year study of high school students in Texas maintain. The students involved in the study, called the Texas Cooperative Youth Study, were from every section of the State and represented several ethnic groups and all socioeconomic levels.

The study found, the authors report, that students in cities were more resentful of parental authority than students in rural areas, though the pressure to conform was greater in small communities than in large. Students from the lower socioeconomic groups tended to support authoritarian parenthood more than those from the upper levels. Students from highly cultured families were better adjusted than others. And, although more students than the investigators expected wanted to go to college, respect for educational achievement was highest among students with educated parents.

The authors conclude that young people "must remain in school" if they are to perform "the paramount obligation" of their adult lives, that is, "the rearing of children in competent families residing in adequate homes." In their opinion, the family is still the first instrument for the socialization of the young and the transmission of culture.

RECLAIMING THE DELINQUENT by para-analytic group psychotherapy and the inversion technique. S. R. Slavson. The Free Press, New York. 1965. 766 pp. $9.95.

This book describes a 6-year experiment in treating seven seriously delinquent 15- and 16-year-old boys, undertaken as a "study in action and in depth" to uncover the "mostly unconscious inner dynamisms of the delinquent boy in our culture."

The author reports that by use of a "para-analytical method" and the "inversion technique" the boys were put into the analytical and introspective moods necessary to therapy. Para-analytic therapy, he says, concentrates primarily on behavior, a major concern of these boys because they were being punished for misbehavior. In thus concentrating on their conduct in group interviews, the boys were helped to realize that understanding the reasons for their behavior was the key to "their salvation." Once they realized this, the author says, the boys readily participated in group interviews characterized by the "inversion technique": an inversion of attention from outside factors to the inward conflicts that had a part in getting them into difficulties.

The author concludes that the work began too late to be entirely successful, but that more progress was made with the boys than might have been by individual therapy. One of his conclusions regarding the "inner dynamisms" of the delinquent, based on an analysis of the group interviews, is that the boy's sense of identity has been so debilitated by experiences of rejection that he can feel "being" only when acting out hatred, anger, and rage at others.

UNWILLINGLY TO SCHOOL: the place of the child guidance clinic in the treatment of school phobia. Jack H. Kahn, M.D., and Jean P. Nursten. Foreword by Mildred Creak. Published by Pergamon Press, Inc., London, England. Distributed by the Macmillan Co., New York. 1964. 187 pp. $2.95.

The authors of this book draw on their own experience with neurotic children to discuss the etiology and treatment of the morbid fear some children have of leaving home for school. They identify three aims for doing so: (1) to consider the problem of school phobia in a practical way; (2) to examine the manifestations of disturbed feelings and behavior in a theoretical framework; and (3) to discuss the interprofessional difficulties of dealing with the disturbed behavior that results in school phobia.

The authors point out that the usual truant often comes from a materially and emotionally poor home and that the child with school phobia often comes from a comfortable home where emotions are intense. The child with school phobia has frequently transferred a conflict from his home problem to the school.

The authors warn against accepting the manifestations of the phobia as causes. They describe treatment in terms of the separate and joint functions of the professional members of a child guidance team—the psychiatrist, the psychologist, and the psychiatric social worker. They also describe the conflicts in practices among workers in the various services which deal with the problem of school phobia and recommend a multidisciplinary method of attacking the problem.

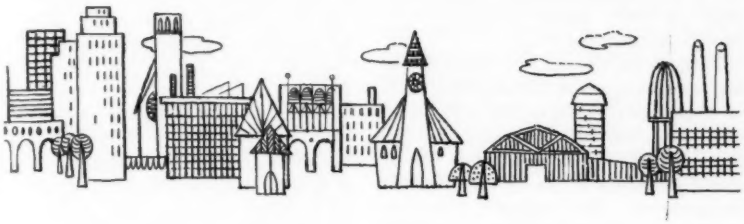
DEVELOPMENT AND DISORDERS OF WRITTEN LANGUAGE, VOLUME I: picture story language test. Helmer R. Myklebust. Grune & Stratton, New York and London. 1965. 278 pp. $7.75.

In this first volume of a 2-volume work on the development of and disorders in written language, the author describes the types and origin of various disorders and gives examples of their effects on writing. A large part of the book is given to a description of a picture story language test developed by the author as a "standardized procedure for appraising normal facility with the written word" and a means of studying, diagnosing, and categorizing "disorders of this type of verbal behavior."

In the test the child is shown a picture about which he then writes a story. The results are scored by standards the author has developed for productivity (length of expression), correctness, and meaning. The book describes the administration of the test, directions for scoring, and norms for written language.

The author reports trying out the test on more than 700 schoolchildren, ages 7 to 17, in 3 schools. The students were from all socioeconomic levels and cultural backgrounds and from urban, suburban, and rural areas. He found that the results of the test for productivity showed the most stable results. On correction, the results showed rapid growth between ages 7 and 9, slight growth between 9 and 11, and virtually none from 11 on. For meaning, results showed gradual growth. Girls progressed more than boys until age 17.

HERE and THERE



Health care

In mid-March, the Chicago Board of Health became the first recipient of a grant from the Children's Bureau to establish comprehensive health services for children of preschool and school age in areas of high concentration of low-income families. Federal grants to provide not more than 75 percent of the cost of such projects were authorized by the 1965 amendments to the Social Security Act. (See CHILDREN, September–October 1965, page 202.)

With the help of the grant, the board will set up and support what it calls COMPCARE centers to offer complete pediatric and adolescent medical care services to children and youth in low-income areas. Teaching hospitals and medical schools will operate the centers, which will be staffed by physicians, social workers, nurses, dentists, nutritionists, health educators, and other professional health personnel. One principle objective is to organize community facilities already in operation into a comprehensive health service for such children.

Negotiations are under way between the Board of Health and several facilities for the establishment of centers: Children's Memorial Hospital in association with the Northwestern University Medical School; Mount Sinai Hospital in association with the University of Chicago Medical School; and the Bobs Roberts Memorial Hospital of the University of Chicago Medical School. These centers will serve an area with an estimated 177,590 children and young people.

The project will go through developmental phases before it is in permanent operation: the recruiting of core staff members; the drafting of agreements, and the setting up of administrative procedures; and the completion of negotiations between the Board of Health, universities, and hospitals.

The general supervison of the project is under the city's Commissioner of Health and the director of the State department of health. The chief epidemiologist of the local Board of Health will aid in the administration of the project, assisted by the director of nurses, the chief dental officer, and the director of nutrition of the board.

To get it under way the project's director will use the services of Board of Health staff members now in the federally aided maternity and infant care project, which he also heads. In addition, the project will draw on the assistance of as many local and State health, education, and welfare agencies as possible (Head Start, the Chicago Board of Education, and the State health department, to name a few) in line with the provisions of Public Law 89–97 that health services set up by the law be coordinated with such agencies and their services used as much as possible.

Child welfare research

Five new grants, totaling $160,919, for child welfare research and demonstration projects have been awarded by the Children's Bureau since the first of the year. They were made to—

- The Lane County Youth Project, Eugene, Oreg.; $28,165, to develop a comprehensive, electronic data system of collecting, processing, and reporting juvenile court statistics which could be a model for courts and a guideline for the further improvement of local, regional, and national reporting procedures.
- The American University, Graduate School of Government and Public Administration, Washington, D.C.; $42,563, to determine costs of child welfare services provided by children's institutions.
- The Council on Social Work Education, New York, N.Y.; $34,776, to conduct a survey of schools of social work faculty and to develop a plan for research on manpower needs in graduate social work education.
- The Wisconsin State Department of Public Welfare, Madison; $22,103, to pretest and develop a study on the use of social work manpower in noninstitutional child welfare services by defining major social work tasks and developing functional statements for types of workers; field testing a plan for use of social work manpower; studying problems concerning the needs in social work education; and developing a civil service classification system for child welfare workers.
- The University of Puerto Rico, Social Science Research Center, Program of Research and Training in Criminology, Río Piedras; $33,312, to conduct a comparative study of the work of juvenile courts in Puerto Rico with juvenile delinquents as part of an international study of the intake and accomplishments of juvenile courts.

. . .

Many children who have been placed in foster care in New York City could have been kept at home had the right services previously been available to their families, according to a study recently completed by the Community Council of Greater New York in cooperation with the New York City Department of Welfare. The study, which was supported by a grant from the Children's Bureau, focused on 891 children placed in foster care for the first time between May 1 and August 31, 1963, and on the conditions existing in the families—425 in all—during the previous year.

The study found five main reasons why placement was necessary: (1) physical illness, incapacity, or confinement of the person caring for the child (29 percent of the families); (2) emotional problems in the child (17 percent); (3) mental illness of the mother (11 percent); (4) severe abuse or neglect (10 percent); and (5) other family breakdown, including desertion and child abandonment, parental incom-

petence, and child rejection (33 percent).

Nearly half (44 percent) the families were one-parent families, the majority of them headed by the mother. About 38 percent of the total were receiving public assistance at the time of placement.

In nearly half the cases (49 percent), the children were kept in foster care no more than 3 months, 16 percent for less than a week. Emotionally disturbed children, however, were usually in care longer.

To help prevent unnecessary placements, the study recommends the provision of around-the-clock child welfare intake services; the provision of funds for paying relatives and family friends for child care; expansion of family and group day-care services; expansion of and more flexibility in homemaker services; stronger protective services; expansion of community psychiatric services; services to strengthen family life; and closer coordination of public assistance and child welfare services in the New York City Department of Welfare.

To provide better care for children requiring placement, the study recommends: more resources for shelter care; an adequate supply of long-term child placement resources for emotionally disturbed children; and improved means of reporting child neglect and abuse. Communities need better data on child welfare services and on the families and children requiring these services, the study concludes.

Copies of the study report, "Paths To Child Placement: Family Situations Prior to Foster Care," by Shirley Jenkins and Mignon Sauber, are available for $3.50 each from the Council, 225 Park Avenue South, New York, N.Y., 10003.

For youth

Young people of high school and college age who are from economically and culturally deprived areas in California are participating in local or statewide community improvement programs through a project called "Youth Participation in Community Action." The project is sponsored by the Governor's Advisory Committee on Children and Youth, administered by the California Department of the Youth Authority, and financed by the Office of Economic Opportunity with a one-year training grant under title II of the Economic Opportunity Act of 1964. In mid-March of this year, 186 young people, 162 of high school and 24 of college age, were at work under the project in various parts of the State.

Through the project, the young people are being assigned in teams of five each, to work and study in public and voluntary agencies on programs to improve social, recreational, and educational resources in the State and local communities. For example, they are helping to organize county youth councils, to establish a neighborhood referral center for teenage employment, to set up a tutorial program for youth, and to design neighborhood self-help projects. In the process they are learning to make surveys of community needs, to serve on local committees with both young people and adults, and to interpret to others the needs of young people from deprived areas. Some of them are also serving on a newly established State Youth Council as well as on regional anl local youth councils. In addition to the professional supervision provided on their assignments, the young people are being provided with formal training sessions.

The college-age participants are serving as supervisory aides on a yearly salary of $1,750. The high school-age participants, called trainees, are paid a minimum of $1.25 an hour for time in service or training.

AFDC policies

Early in February, the NAACP Legal Defense and Educational Fund, Inc., formally challenged both the legality and constitutionality of the "substitute parent" policies which in some States prevent otherwise eligible families from receiving assistance in the Federal-State program of aid to families with dependent children (AFDC). The challenge was made through a complaint filed with the Secretary of Health, Education, and Welfare against the programs in the States of Arkansas and Georgia, along with a petition for a hearing to determine whether these programs were out of conformity with the requirements of the Social Security Act or for a specific ruling on such policies.

The complaint charges that "substitute parent" policies—which regard a man who has regular social or sexual relations with a woman as responsible for the support of "any child had by that woman" regardless of his ability or willingness to support—are subverting the purposes of the AFDC program by creating a new meaning for the word "parent." It maintains that such policies are serving as devices for carrying on the "suitable homes" criteria for eligibility to AFDC outlawed by former Secretary of Health, Education, and Welfare Arthur E. Flemming in a ruling made in 1961 as a result of a hearing on Louisiana AFDC policies. (See CHILDREN, March-April 1961, page 73.)

The complaint also charges that "substitute parent" policies not only violate title IV of the Social Security Act but also flout the constitutional right of all citizens to associate freely with one another, by forcing needy mothers whose husbands are dead or have deserted them "to either abandon their right to privacy and dignity in social relations or to maintain social relations with male friends in a secret and socially destructive manner." It points out that in both Georgia and Arkansas the burden is put on the client to prove that a man she has been seen with is not living in her home or having relations with her.

Through their attorneys, two women from Arkansas and two from Georgia joined in filing the complaint and petitions. Three of the women had had similar experiences: Each had been denied aid on the presumption that a man by whom she had had a child born out of wedlock would support the children in her family who were not his. The fourth woman, a widow active in the civil rights movement, had been continuously threatened with denial of aid if she allowed visiting voter registration workers to stay in her home.

Handicapped children

The Winfield State Hospital, one of three State hospitals in Kansas for the mentally retarded, is conducting a study on the use of changed feeding techniques to improve nutritional status in children who are both mentally and physically handicapped. The study is being financed with a $12,000 grant from the Kansas State Department of Social Welfare.

The study is based on the assumption that some malnutrition in severely re-

tarded children is directly related to the inability to eat enough nourishing food and that the usual methods of feeding on the wards may interfere with or impede the development of the child's natural ability to suck, chew, and swallow. Two groups of malnourished, severely retarded children are being studied, each consisting of 12 children who because of neurological damage do not have normal sucking, chewing, and swallowing patterns. One, the experimental group, will live on a controlled ward in which procedures will focus on the provision of intensive therapy in eating techniques. The other group will live on the regular wards and continue to be fed by normal ward methods.

The techniques used with the experimental group will be based on methods developed to stimulate sucking and swallowing. The children will be encouraged to respond to repeated stimuli which include the taste and texture of food, massaging of the lips, and gentle stroking of the cheeks and throat.

An integral part of the study is the management of ward procedures in regard to feeding such as the scheduling of the duties of workers and the use of part-time employees at meal hours. It will also include work on nutritional problems and specific dietary needs.

Speech and hearing

The use of subprofessional workers in programs for children with speech and hearing handicaps was both criticized and supported by participants in the National Conference on Training in Speech Pathology and Audiology which the Children's Bureau sponsored last January in Washington, D.C. Consequently, participants recommended that the American Speech and Hearing Association undertake a study of the use of manpower in this field to determine which tasks might be performed acceptably by subprofessional workers under professional supervision.

The conference brought together representatives of six institutions conducting training supported by the Bureau and six Federal agencies concerned with the training of persons with speech and hearing handicaps.

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At a conference in Denver in February, the directors of speech and hearing programs in the health and welfare departments of the 10 States served by the Dallas and the Denver regional offices of the Children's Bureau discussed, among other topics, the question of requiring hearing-aid dealers to obtain licenses. Participants reached no conclusion on the advisability of setting up this requirement.

Of the States represented, only Oregon now requires licensure for hearing-aid dealers, but several other States are considering legislation to that effect.

Health research

In late March the Children's Bureau awarded 10 grants, totaling $262,020, for research or study projects in maternal and child health and services for crippled children—7 for new projects, 3 for the continuation of projects begun under previous grants. The grants for new projects were awarded to—

- North Shore Hospital, Manhasset, N.Y., $28,074, to test for galactosemia (a congenital metabolic disease which usually results in mental retardation) about 15,000 3- to 5-day-old infants in community hospitals.
- Children's Memorial Hospital, Chicago, $4,500, to determine the incidence and trend of breast feeding in the United States, through a sample study of the extent of the practice among mothers at the time they leave the hospital and comparsion of the results with the findings of two previous studies conducted 10 and 20 years ago.
- University of Southern California, Los Angeles, $14,249, to study the effect of sensorimotor training on the perception and learning of neurologically handicapped children.
- University of North Carolina School of Public Health, Chapel Hill, $7,776, to determine the nutritional resources available to and the dietary practices of young women during pregnancy who were delivered at two large public hospitals in New York City.
- Temple University School of Medicine and its hospital, Philadelphia, $17,952, to determine whether methods recommended by health workers for preparing formulas for infants are followed in the home, whether and how they are modified by socioeconomic factors, and whether simpler methods can safely be substituted.
- Northwestern University, Department of Physical Medicine, Evanston, Ill., $61,071, to set up a workshop to re-examine methods of therapeutic exercise in order to effect improved curriculums at physical therapy schools.
- University of Kentucky Medical Center, Lexington, $37,744, to determine the most effective way of operating a care-by-parent in-hospital pediatric unit for chronically ill children from an Appalachian region of Kentucky.

Education

By late March the Department of Health, Education, and Welfare had started proceedings against 80 school districts in 6 Southern States to determine if they are complying with the Civil Rights Act of 1964 and should continue to receive Federal aid. The districts either submitted desegregation plans unacceptable to the U.S. Commissioner of Education or no plans at all. Sixteen of the districts have come into compliance since proceedings began and action against them has been dropped. Federal hearing examiners have handed down initial decisions in 36 cases, all against the continuation of Federal financial assistance. The decisions are being reviewed by the Commissioner of Education, and are subject to review by the Secretary of Health, Education, and Welfare.

. . .

The Pennsylvania State University, under contract with the U.S. Office of Education, is preparing a guide for a post-high school program for training workers in the field of child care. A response to the rapidly growing demand from day-care centers, nursery schools, and other facilities for persons trained to assist their professional workers in the care of young children, the guide is intended for use by junior colleges, community colleges, and area vocational schools.

Child welfare services

Federal, State, and local public welfare agencies spent $352 million for child welfare services in fiscal year 1965, an increase of 12.5 percent over 1964, according to recent estimates of the Children's Bureau. Of the total, 90 percent came from State and local funds. The Federal contribution in 1965 was $34.2 million, a rise of $5.4 million over the previous year; the State, $176 million, a rise of $20 million; and

the local, $141.8 million, a rise of $13.6 million. These figures do not include expenditures by State and local public welfare agencies for operating institutions and group homes for "dependent and neglected children," which in 1965 amounted to $17.2 million.

The amount spent for child welfare services has risen steadily since fiscal year 1960, when the total was $211.1 million. The expenditure per child under 21 years old was $2.93 in 1960; $4.37 in 1965.

As in the past the largest proportion of the total in 1965 went for foster care: 65 percent. Provision of day-care services took 2.6 percent; personnel costs, 26.6 percent; and educational leave, 0.9 percent. The rest was for miscellaneous expenses.

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The provision of services to children in their own homes—including protective services in cases of neglect or abuse and services to unmarried mothers—is one of the numerous recommendations to come out of a study of the Massachusetts public welfare system, made by the National Study Service under the sponsorship of the Massachusetts Committee on Children and Youth and the United Community Services of Metropolitan Boston.

The recommendations call for a complete reorganization of the State's public welfare system through assumption of full administrative and financial responsibility by the State Department of Public Welfare and development of some 50 community service centers through which a broadened and integrated program of services would be operated, including the program of aid to families with dependent children and child welfare services.

The recommendations also call for:

- Integration of the public assistance and general relief categories into a single program based only on need; and the establishment of more nearly adequate budgetary standards for children on assistance.
- Broadening the public agency's adoption services to include children beyond infancy.
- Expansion of homemaker and day-care services to children and the aged.

. . .

The Mississippi State Department of Public Welfare, Division of Child Welfare, is presently enlarging its adoption program to provide direct services for all applicants. Until recently, the division referred white infants needing adoption to a voluntary social agency, but no longer does so since the voluntary agency does not meet the requirements of the Civil Rights Act. The division's enlarged service includes service to unmarried mothers, adoptive studies, and placement and supervision of children in adoptive homes. It is now reviewing standards of practice and recruiting additional staff members.

. . .

The Nation had about 23,700 licensed or State approved day-care facilities with space for about 310,400 children at the end of September 1965, according to Children's Bureau statistics. Of these facilities, about 7,330 were day-care centers with space for about 252,000 children and 16,370 were family day-care homes with space for about 58,400 children.

Forty-seven States, the District of Columbia, Puerto Rico, and the Virgin Islands include day-care programs in their Federal-State child welfare services plans. Under these plans 7,691 children received day care supported by public funds between July 1 and September 30. On the latter date, 33 States were paying for the day care of 3,253 children enrolled in day-care centers and 22 States, for the day care of 1,329 children in family day-care homes.

Juvenile delinquency

Approximately 686,000 juvenile delinquency cases (excluding traffic offenses) were handled by U.S. juvenile courts in 1964, a 14-percent increase over the previous year as compared to a 4-percent increase in child population, according to estimates of the Children's Bureau based on reports from a national sample of juvenile courts. Because some children were referred more than once, the actual number of children involved was somewhat lower—591,000. Estimates based on these figures indicate that one out of every nine children will be referred to a juvenile court for delinquency (excluding traffic offenses) before age 18.

The reports showed that—

- Four times as many boys as girls were referred to courts for delinquency. The offenses committed by boys and girls differ. About half the boys but only a sixth of the girls were referred for offenses against property. Girls were referred most often for truancy, running away, and unmanageability.
- The fastest increase was in semi-urban areas.
- One half of the cases were handled by the juvenile courts without a petition being filed (nonjudicially).
- The largest group of offenses for which juveniles were referred in large cities (41 percent) consisted of those committed against property.

These and other facts are contained in "Juvenile Court Statistics—1964" (CB Statistical Series No. 83). Single copies are available from the Bureau without charge.

Miscellaneous

The United Nations Children's Fund (UNICEF) recently granted consultative status to the International Planned Parenthood Federation (IPPF). This means that a representative of IPPF may attend UNICEF Executive Board sessions and may speak on topics of interest to the board and to IPPF. The subject of UNICEF's role in family planning is on the agenda for the UNICEF Executive Board meeting, being held in May in Addis Ababa, Ethiopia.

. . .

The number of births in 1965 in the United States—3,767,000—represents the smallest number since 1951, according to provisional figures recently released by the U.S. Public Health Service (PHS). The crude birth rate for 1965 was 19.4 per 1,000 persons, close to that recorded in 1938. Despite the drop in numbers, however, the fertility rate (number of births per 1,000 women, aged 15–44 years) is well above the 1938 level. In 1965 there were 96.7 births per 1,000 women aged 15–44 as compared with 76 to 79 in the period 1933–39.

Oversight

CHILDREN extends an apology to Dr. Richmond S. Paine, Children's Hospital of the District of Columbia, for failing to give him credit for the photograph of the chromosome karyogram used as the basis for the drawing on page 61 of the March–April 1966 issue.

READERS' EXCHANGE

PAULSEN: *The child is the concern*

When an instance of the brutal abuse of a child bursts upon the community in headlined news stories, the blood of all responsive people boils. But boiling blood is a notoriously poor solution in which to cook up logic. Thus it is good to see Professor Paulsen treat the issue in a quiet and scholarly manner. ["Legal Protections Against Child Abuse," by Monrad G. Paulsen, CHILDREN, March–April 1966.]

The greatest need in this area of social work is to be reminded that society's first concern should be for the welfare of the child, leaving retaliation and retribution aside. The Good Samaritan in the Bible did not take off in pursuit of the robbers. He left that task to the sheriff, if there was one in those days. Instead, he took the victim to an inn and arranged for his care. In the same manner, juvenile court judges should spend their energies in mending the child's injuries and taking the steps necessary to insure safe care for the child thereafter—at home if that is possible, or in a substitute home if need be.

I tend to agree with The American Humane Association's recommendation that suspected cases be reported to a child welfare agency (where such exists) rather than to the police. Not that policemen cannot be Good Samaritans, but they more often give priority to the criminal and punitive side of such cases. Protective service agencies are also less likely to inform the press and inflame the community.

Battered child cases, as they have come to be called, although few in number, impose a severe strain on the theory that a community can have a free press and also provide a fair trial. There are cogent reasons why the reporting statutes which have been passed so expeditiously in 47 States should provide that such reports be handled in a confidential manner until a court has acquired jurisdiction and made at least a preliminary adjudication. Such a provision would be protective of the child's safety as well as the right of the parents to a fair hearing. As soon as the newspapers publish the allegations the pressure mounts for quick and drastic action. The opportunity for an impartial social investigation is precluded. Angry letters arrive by the bushel, and the community demands its pound of flesh even before the judicial hearing.

Because most juvenile court judges face such cases only occasionally, I recommend they read Professor Paulsen's article with care and gain some preliminary insight into this special and troublesome area of child neglect cases. Like a home fire, there is seldom time for dispassionate thinking when such a case breaks upon a community.

Orman W. Ketcham
Associate Judge, Juvenile Court of the District of Columbia, and President, National Council of Juvenile Court Judges, Chicago

GARRETT et al: *Families for babies*

Congratulations to CHILDREN for the timely emphasis on foster care in the January-February 1966 issue.

Miss Garrett's thoughtful article ["Meeting the Crisis in Foster Family Care," by Beatrice L. Garrett] and Professor Meier's followup study of former foster children ["Adults Who Were Foster Children," by Elizabeth G. Meier] will perhaps encourage agencies to expand long-term, permanent foster-care facilities for children who lack the security of wholesome family life, but for whom adoption is unlikely. The Elizabeth Herzog-Rose Bernstein article—"Why So Few Negro Adoptions?"—in the January-February 1965 issue should be considered as a companion piece to the January-February 1966 articles on foster care.

Among the latter, Aileen B. Ostazeski's report of an experiment in placing children in permanent foster homes ["Preparation for Permanent Foster Care"] coincides to a considerable degree with the experience of the Spence-Chapin Adoption Service. In September 1962, we undertook a 5-year demonstration project designed to remove well babies from New York City hospital wards and to place in long-term foster family homes those who could not be returned to their natural families and for whom adoption was unlikely. In the ensuing 3½ years, we have served 965 such children, most of them Negro and Puerto Rican. After some casework with their natural parents, 176 of the children could be returned to their own families. Of the others, 143 have been placed in adoption, mainly with their former foster parents. The remainder, 646, are in long-term foster family care; only 50 have had to be transferred from one foster home to another.

Like Mrs. Ostazeski, we have found that: Permanent foster care involves many of the same elements as adoption; the selection of foster parents for specific children is essential; the foster parents must be allowed to act and to feel as though they were the child's natural or adoptive parents; and a "family"-oriented approach with foster parents, concentrating on working with the foster parents' ego strength, is essential.

Social agencies can no longer ignore the imperative need for permanent foster family care for children for whom adoption is unlikely, as it is for so many children of minority groups. As Sterling Tucker once stated in *Child Welfare* [November 1962]: ". . . the adoption gaps [among Negroes] will be bridged only when the other gaps [in housing, employment, education, and so forth] standing in the way of total family security have been bridged."

Helen B. Montgomery
Executive Director, Spence-Chapin Adoption Service, New York

MALUCCIO: *Supporting foster parents*

I greatly appreciated the article, "Selecting Foster Parents for Disturbed Children," by Anthony N. Maluccio [CHILDREN, March–April 1966], but I had to make several assumptions to apply its message to my own experience. I had to assume that there is adequate agency support of the foster parents in the forms of remuneration and casework service (to both foster parents)

as well as growth-producing supports to the foster child at all stages of placement, including special education if needed. I had to assume that the specific family and specific child were matched in relation to their needs so that the experience would be mutually growth-producing.

While I agree with Mr. Maluccio that the ego strengths of the foster parents need to be assayed with particular awareness to the shifting imbalances and stresses of a child in treatment, I find it hard to evaluate these in the abstract. Very few families come to us who could handle the wide variety of personality problems that our children present. In all cases the balancing of individual personality needs and capacities is of vital import in the selection of a particular family for a particular child. Even when this has been attempted, the agency may need to provide psychotherapy for a member of the family whose equilibrium has been upset by presence of the foster child.

If these commitments are not a basic part of its foster parent program for children, whether or not they are emotionally disturbed, the agency runs the risk of turning away parents who under the right conditions could serve a child well, or the risk of burdening a family to the breaking point.

As an example of this, I would refer to the B family in the article. How much was Mr. B included in the casework process while Mrs. B was devoting herself to George's infantile needs? Traditionally, casework is provided almost exclusively to the foster mother during such a period and too often the result is eventual alienation of the father.

It was most fitting, I felt, that CHILDREN followed the article with a quotation addressed to the responsibility of the community to support the foster parent adequately. The reference was to financial support but could be as appropriately interpreted to mean adequate professional development and support.

George E. Gaby
Casework Director, Children's Study Home, Springfield, Mass.

in the journals

Classes for unmarried mothers

Two articles in *Nursing Outlook* for March 1966 focus on health education for unmarried mothers. ("Health Education Classes for Unwed Mothers" and "Parent Education Groups for Unmarried Mothers.")

In the first, Maralee Burton and Ilverine Holter, both public health nurses on the teaching staff of South Dakota State University, describe a teaching program for unmarried pregnant girls in a residence home for 44. The focus was on health during and immediately after pregnancy. The program used demonstrations of exercises, films, printed matter, and group discussions. The authors found that the girls lacked basic knowledge of anatomy and physiology and that most material on pregnancy is "family-centered."

In the second, Aline B. Auerbach and Mildred Rabinow of the Child Study Association of America report on a session on parent education groups for unmarried mothers in a conference for nurses held in New York City. According to the authors, the nurses concluded that group educational experience for unwed mothers can and should furnish unmarried mothers with opportunity to learn about the physical aspects of pregnancy, labor, and delivery, and what they will face in providing for the baby, and pointed out that the nurse is in a "particularly favorable position" to help the unmarried mother.

Child welfare staff

Two articles in the March 1966 issue of *Child Welfare* deal with staff needs and the preparation of workers for the child welfare field. ("Education and Training for Child Welfare: A Realistic View," by Elizabeth A. Lawder, and "From the Point of View of the Undergraduate School," by Margaret B. Matson.)

In the first article, Dr. Lawder, executive director of the Children's Aid Society of Pennsylvania, says that, because of the chronic shortage of workers, agencies should clearly define the responsibilities of professional, nonprofessional, and clerical workers and let community leaders know that they do not have enough workers to provide professional services at all times. She maintains that agencies "cannot let pass for professional competence what is not," and that "only when we make manifest the need for inservice training, for new patterns of organization, and for better collaboration among agencies and schools of social work will we achieve better results."

In the second article, Dr. Matson, director of the social welfare major at the Pennsylvania State University, stresses the importance of undergraduate social work offerings in the recruitment and education of beginners for the child welfare field and emphasizes the need for closer cooperation between agencies and educational institutions in the provision of such educational opportunities. She particularly stresses the value of agency field placements for undergraduate students and the need for delineating the beginners' tasks.

The young deaf child

Because language develops during the early years, the parents of a prenursery school-age deaf child should use their day-to-day contacts with him as much as possible to help him acquire language, Audrey Ann Simmons maintains in the March 1966 issue of *The Volta Review*. ("Language Growth for the Pre-Nursery Deaf Child.") Describing a 6-year "parent-centered" program conducted by the Central Institute for the Deaf in St. Louis, she says that "when parents are given an insight into the problems of deafness and an idea of the principles of language growth proceeding speech development, they can accomplish much with their own children."

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PARENT AND FAMILY LIFE EDUCATION FOR LOW-INCOME FAMILIES: A GUIDE FOR LEADERS. Louise Proehl Shoemaker. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 434. 1965. 66 pp. 30 cents.

This guide grew out of a conference of practitioners in parent education programs which was arranged by the Subcommittee on Parent and Family Life Education of the Interdepartmental Committee on Children and Youth.

ADOPTIONS IN 1964. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 8 pp. (Multilithed.) Single copies available from the Bureau without charge.

About 135,000 adoptions were completed in the United States in 1964, according to this report, which presents statistics for 48 States, the District of Columbia, Puerto Rico, and the Virgin Islands, and estimates for 2 nonreporting States. It shows that 53 percent of the children involved were adopted by nonrelatives; about two-thirds of all adoptions by nonrelatives were arranged by social agencies; about 10 percent of all the children adopted were nonwhite; and about 61 percent (82,400) of the total were born out of wedlock.

SERVICES UNDER AFDC FOR CHILDREN WHO NEED PROTECTION. Claire R. Hancock. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. 1965. 45 pp. 40 cents.

This publication offers guides to public assistance workers on how to help parents with serious problems in child care, how to recognize signs of child neglect, abuse, or rejection, and when and how to make a referral for child welfare services. Appendixes include excerpts from case records and a bibliography.

STATISTICS ON PUBLIC INSTITUTIONS FOR DELINQUENT CHILDREN—1964. Alair A. Townsend. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Statistical Series No. 81. 1965. 39 pp. Single copies available from the Bureau without charge.

Reports information on the number of children in various types of public training schools for delinquent children, numbers committed and discharged, returnee and runaway rates, and institutional costs and personnel, from data provided by 245 of the 274 institutions for juvenile delinquents in the United States (including Puerto Rico and the Virgin Islands).

Findings indicate, among other facts, that: (1) 37 percent of the training schools were overcrowded; (2) 28 percent of the children entering the schools in 1964 had been admitted previously; and (3) nearly a fourth of all employees of the institutions left their jobs in 1964, including 67 percent of the treatment and educational employees.

WHEN YOU ADOPT A CHILD. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 13. 1965. 27 pp. 15 cents.

This revision of a 1958 pamphlet answers some of the questions that should be considered by couples or parents who are planning to adopt a child.

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